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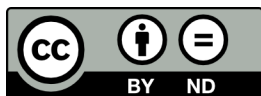
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Oxford Doctoral Course in Clinical Psychology

**An exploratory study of factors
associated with therapists offering 26 or
more sessions of therapy**

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(B.Sc., M.Sc.)**

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Abstract

Longer therapies can have a major impact on services by lengthening waiting lists. This exploratory study of one National Health Service (NHS) adult mental health psychology department aims to understand why therapists gave longer therapies to a few of their patients. There is a paucity of research on this topic in the literature. A longer therapy was defined as one of 26 or more sessions since some research has shown that at around this number the rate of improvement levels off. A qualitative research methodology using grounded theory was employed to analyse data obtained from interviewing nine psychologists.

The main findings comprised two related themes: the stages that therapy goes through, during which it becomes extended; and balancing competing demands while carrying out the therapy. These conflicts may be coped with in different ways, but they often result in the therapist finding it difficult to stop therapy, even when they review frequently. The therapist may then ask a colleague for advice to help them stop. The therapist may keep their feelings, and behaviour secret, which may make it difficult for them to maintain their self-esteem. The conflicts may remain unresolved.

The methodology and findings are discussed critically. Recommendations are made, from the findings and using ideas from the literature, to help the members of the department (and other therapists) stop therapy sooner, and to become more open about the length of the therapies they give.

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1 Introduction

1.1 Topic of investigation

This dissertation is concerned with uncovering the factors leading therapists (psychologists) to offer many more sessions, than they usually do, to some of their patients. This occurs in the context of other demands on the therapist, many of which may create a pull towards a briefer therapy. Giving longer therapies can become a problem because it can have a disproportionate effect on waiting lists compared to shorter therapies.

1.2 Background

Recently, partly because of evidence-based research findings and also because of financial considerations, shorter psychological treatments have been encouraged in the NHS, and Trusts are expecting therapists to see more patients. Additional factors, such as long waiting lists, departmental policies and pragmatic reasons, may all be pushing this drive towards relatively short-term treatments (Startup, 1994).

It is possible that the length of therapy (in the NHS) is now shorter, on average, than in the past (Startup, 1994). But this may not be a consistent phenomenon. It should be noted that clinicians often ignore research findings, including those of treatment length (Morrow-Bradley and Elliott, 1986; Roth, 1999; Waddell, 2001). Firth, Shapiro, and Parry (1986) suggest that therapists often covertly depend on a fall-back possibility of extending the number of sessions despite what has been agreed. Punter (1995) found that, in an NHS psychotherapy department, treatment length of patients allocated to short-term individual therapy was between two and 249 weeks. Thirty-two percent had therapy for between one

and 4.7 years and this was no different from those allocated to long-term treatment. By most accepted definitions this would not be considered 'short-term'. Punter's study was an audit and did not explore the reasons why some of these therapies had exceeded what must have been agreed at assessment.

A similar phenomenon was found in an audit carried out in the psychology department under investigation for this study. The norm in the department was giving around ten sessions of therapy but some psychologists offered considerably more to a few patients. It was found that 22 long-term patients took up as much time as about 170 'average' 13-session patients (Westbrook, 1999). Indeed, four of these 22 patients had had as many sessions as more than 100 'average' patients. Westbrook's audit did not investigate the reasons for this occurrence.

It would seem reasonable to surmise that, when some patients get considerably more than the 'average' number of sessions, this can have severe consequences for waiting lists and for the service. It seems likely that the length of the waiting list will increase, resulting in a much longer wait for many patients. Given that long-term therapy may not necessarily be more effective than short-term (see Section 1.3) it is important to increase our understanding about why this phenomenon occurs, whether in the department under investigation or in others. The current study is an attempt to explore possible reasons for this happening, in one Adult Mental Health Psychology Department. Problems around finding an optimal length of therapy had exercised the department for some years, and the present study is an attempt to find out more. If the reasons were known it might be possible, in this one department or in others, to devise ways of ameliorating their negative effects, as well as endorsing when it is justified. For this study, longer therapies are defined as those of

26 or more sessions (Section 1.4), and brief therapy as up to ten sessions. Although the focus of the study is parochial, the findings are likely to have relevance to therapists in other departments.

1.3 Literature review

1.3.1 Length of therapy

As already suggested, samples from individual clinics and epidemiological studies have often found that a comparatively small proportion of patients consumes a disproportionate amount of resources i.e. these patients have many more sessions than do most patients (Garfield, 1986; Vessey, Howard, Lueger, Kächele, and Mergenthaler, 1994; Westbrook, 1999). For example, Howard, Davidson, O'Mahoney, Orlinsky, and Brown (1989), when studying 405 patients, found that 32% of patients used 77% of all sessions. Garfield (1986) found that, even where an unlimited number of sessions was on offer, the median number of sessions was only five to six, in other words, most patients have few sessions while a few will have a great many sessions.

1.3.1.1 Is more therapy better?

Therapists have long had an assumption of 'more is better' (Stiles and Shapiro, 1989). Guinan (1995) and Jones (1998) are critical of the 'rapid throughput model' that clinical psychologists have adopted as a response to NHS 'reforms'. Older studies, often of psychodynamic therapy, have backed the 'more is better' assumption (Howard, Kopta, Krause, and Orlinsky, 1986; Orlinsky, Grawe, and Parks, 1994; Seligman, 1995). More recently, Stiles (1996) has stated, in the context of process-outcome research, that 'more of a good thing is better when one is not already getting enough', which could apply to length

of therapy as well as process factors. However, this begs the question of knowing when the point of 'enough' has been reached, and how it should be measured. Steenbarger (1994) suggests that there may be a continuum of patients where, at one end, are those who readily form a treatment alliance and have a focal problem, who can achieve their goals in very few sessions (e.g. 10). At the other end of the continuum, are those patients who have diffuse problem patterns and with whom building a treatment alliance takes time. The latter group of patients would need more sessions.

1.3.1.2 The 'dose-effect' relationship

The curve of outcome and treatment duration is not necessarily linear and has been found to be negatively accelerated. In other words, a point is reached (which differs with factors such as type of patient and treatment modality) when more does not mean substantially better. This is the well-known 'dose-effect' relationship (Howard *et al.*, 1986; Orlinsky *et al.*, 1994). For example, Howard *et al.* (1986) using 15 studies, found that 25% of patients had improved after one session, 50% after eight sessions, and 75% of patients had improved by 26 sessions. After this, the rate of improvement slowed down significantly. It seems that most therapeutic benefits occur in the earlier stages of therapy (Lambert and Bergin, 1994). Kopta, Howard, Lowry, and Beutler (1994) from a sample of 685 patients, estimated that after 58 sessions, 75% of outpatients (i.e. mainly those with anxiety, depression or personality disorders, and a few with psychosis) would have shown symptomatic recovery.

1.3.1.3 Mediating factors

Some researchers have investigated factors that may mediate duration and outcome of therapy (e.g. patient factors – the patient's inter-personal functioning, involvement and

expectation; therapist factors – influence and capacity for relatedness; and context-related factors such as patient-therapist match) (Steenbarger, 1994). Others have described stages in therapy (Shapiro, Barkham, Reynolds, Hardy, and Stiles, 1992; Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro, and Hardy, 1990); phases that therapy needs to go through to be effective (Howard, Lueger, Maling, and Martinovich, 1993); or universal change processes (Orlinsky *et al.* 1994; Kolden, 1996).

From such studies it is possible to conclude that it is not at all easy to generalise about what would be an optimal length of therapy for an individual patient, especially since this could vary according to who decides what is ‘optimal’ – the patient, therapist or manager.

1.3.1.4 Outcome with brief therapy

Koss and Shiang (1994), in a review, suggest that outcome research on brief therapy indicates that it can result in positive change, particularly when specific client groups are studied. Shapiro, Barkham, Rees, Hardy, Reynolds, and Startup (1995) have shown that an eight-session therapy for depression can be effective, and as effective as one of 16 sessions. Further analysis of these data showed that, whilst change in symptoms was roughly linear (i.e. not negatively accelerated) for both groups, change was more rapid in the short, time-limited group (Barkham, Rees, Stiles, Shapiro, Hardy, and Reynolds, 1996; Reynolds, Stiles, Barkham, Shapiro, Hardy, and Rees, 1996). However, both groups had relatively short therapy and may not have had sufficient sessions to demonstrate negative acceleration. The findings from a small-scale study (carried out in the department under investigation), comparing the effectiveness of long-term and short-term therapy for 29 patients with long-standing difficulties, showed that giving ten sessions can be effective, and as effective as 30

sessions (Westbrook, 2001). The therapists in this study were very experienced and had frequent supervision, which may have helped them pace the sessions and maintain focus.

Although it seems that briefer therapies can be effective and most change can occur in the early sessions of therapy, this may vary with symptomatology. Other patient-, therapist- and context-related factors can also affect the number of sessions required for change and outcome obtained.

Importantly, the research quoted above relies on grouped findings and each individual patient may, in practice, be very different in the number of sessions they need for an effective therapy.

1.3.2 Clinical judgement

Therapists can use clinical judgement to determine treatment length, and this is an example of the decision-making people carry out in everyday life. Generally, people try to make accurate and rational judgements, even though this may not always be successful. Some kinds of clinical judgement are easier to make than others, for example, Garb (1994) commented that clinicians are better at monitoring improvement by observing changes in mental state than at predicting outcome.

Much of the literature on clinical judgement relates to making diagnoses and few researchers have investigated therapist decisions about treatment, especially its duration. O'Donohue, Fisher, Plaud, and Curtis (1990) state that clinicians tend not to use systematic processes regarding which assessment and treatment methods to use. This was also found by Gilje and Klose (2000) in psychiatric nurses who used intuitive interpretative decision-

making more than rational decision-making when planning an intervention. Rabinowitz (1993) points out that practitioners' biases can occur at different stages of decision-making – at input, processing, output-action, and feedback.

To help themselves, especially when dealing with complex decision-making, it appears that people use various strategies (heuristics), which may or may not be in their awareness, to simplify the process. These strategies make decisions easier, and often more accurate but can lead to errors when the assumptions they are based on are incorrect, thus leading to bias. Common strategies are that clinicians make early judgements and resist modifying them in the light of further evidence; or choose what readily comes to mind when estimating the frequency of an occurrence, rather than looking at the evidence (Tversky and Kahneman, 1974, cited in Garnham and Oakhill, 1994, page 160). Watts (1980) refers to the adoption of heuristics as a high-risk strategy, and suggests that clinicians increasingly take up these strategies with clinical training and as they become more experienced.

The research literature is also concerned with how clinicians might go about minimising biases (Arkes, 1981; Garb, 1994; Rabinowitz, 1993). Watts (1980) thought that clinical judgement could be improved by training clinicians to use objective low-risk styles, e.g. obtaining objective information, as well as to use more 'qualitative' judgements such as those derived from observations. Reducing bias tends to involve collecting appropriate information and considering alternative hypotheses; relying less on memory and more on notes; and being familiar with the empirical evidence rather than relying on one's own experiences.

While the participants in this study are likely to be using clinical judgement when making decisions about when to extend or stop therapy, other factors, such as the patient and the system, will also have an effect.

1.4 Rationale and aims of the study

The main points discussed above may now be summarised. The research literature has long suggested that positive outcome increases with duration of therapy, but it seems that there may be diminishing returns after a certain point. In some studies this negative acceleration occurred after 26 sessions (Howard *et al.*, 1986). Recent group findings show that briefer therapies can be effective, although it can be difficult to determine the most appropriate length of treatment in individual cases. Yet research evidence suggests that findings are not always acted upon by clinicians in their own practice. Even in settings that tend to offer brief therapy, therapists are likely to offer a few patients considerably more than the average number of sessions.

Although very few patients may be involved, it is clear from first principles, that a large increase in sessions above the norm for a service could lead to problems and have a substantial effect on its waiting list. To decrease this effect, it could be argued that these extra sessions should be discouraged, or at least justified (e.g. by a proportionate improvement in the patient; or by preventing expensive hospitalisation). At the very least, it is likely that therapists are offering more sessions for what they believe to be a good reason. If the factors leading to 'extra' sessions were better understood and were more explicitly known, it might be possible to find ways of minimising their negative effect, e.g. even slightly fewer sessions will have a beneficial effect on the service.

The research mentioned above does not inform about what prompts therapists to offer the number of sessions they do offer, or when during therapy, this occurs. The decisions are likely to be made in the context of other demands upon them, apart from the patient, such as from the setting in which they work. There is no research that tries to understand the beliefs and decisions of individual therapists.

This study aims to discover and examine what therapists (psychologists) believed had led them to offering ‘longer-term’ therapy to some of their patients. A longer therapy is defined here as 26 or more sessions, i.e. using Howard *et al.*’s (1986) cut-off (the number after which 75% of patients had improved, and after which there was negative acceleration). This study is exploratory and uses a qualitative research methodology.

The research question is ‘*what factors are associated with therapists offering 26 or more sessions of therapy?*’

As with qualitative research in general, there will be no predetermined hypotheses. The theme emerging from the findings can be viewed as a hypothesis that could be tested in the future.

1.5 Methodological issues

1.5.1 Qualitative research

The methodology used in a research project flows from the research question (Barker, Pistrang, and Elliott, 2002; Henwood and Pidgeon, 1995). A quantitative methodology looks for cause-effect relationships through the testing of hypotheses. This approach is not

possible with the research question for this study because there is no previous research from which to devise a research methodology using hypothetico-deductive methods. The study is therefore exploratory, and aims to find and understand idiosyncratic meanings, as well as exploring the participants' subjective viewpoints. The study also recognises the importance of the social context and its nuances. These requirements are more readily satisfied by a qualitative methodology. The study aims to understand and find meanings surrounding the offer of longer therapy through open-ended exploration using induction. Again, this is more readily achieved through a qualitative discovery-oriented approach.

It is important to understand that, when using a qualitative approach, knowledge is built up within a social context which includes the participants and the researcher. Thus it is not objective but instead gives their multiple perspectives (McLeod, 2001). The findings do not aim to be the fixed truth and thus are likely to be temporary and tentative (Stiles, 1993). However, by increasing understanding, new possibilities are opened up. Reflexivity on the part of the researcher is particularly important. The researcher analyses their own assumptions but stands back from them (McLeod, 2001; Willig, 2001). Although qualitative research is discovery-orientated, the findings also need to be 'realistic' in order to be plausible (McLeod, 2001).

1.5.1.1 Trustworthiness

In qualitative research there is nothing strictly comparable to the reliability and validity criteria used in quantitative research methods because it does not aim for objectivity.

Nevertheless, qualitative researchers are concerned about quality standards for their research (Elliott, Fischer, and Rennie, 1999; Mays and Pope, 1999; McLeod, 2001; Smith,

1996; Stiles, 1993). Stiles (1993) has referred to the counterparts of reliability and validity in qualitative research as 'trustworthiness' while Elliott *et al.* (1999) call it 'credibility'.

Stiles (1993) suggests some criteria for procedural trustworthiness standards through the trustworthiness of data which include the researcher's 'forestructure' (which has been referred to as 'owning one's own perspective' by Elliott *et al.*, 1999); describing the social context of the research; disclosing the researcher's internal processes; iteration, i.e. repeatedly going between interpretation and data; engagement with the material; and grounding of interpretations in the data. In other words, the steps taken are transparent to others.

Stiles (1993) refers to the trustworthiness of the interpretations of the data or conclusions as being whether an interpretation is internally consistent and useful. This can be determined through the impact of the interpretations on the participants, researcher and reader. It can also be determined by the following methods: triangulation (e.g. seeking information from multiple data sources or from several perspectives); a clear exposition of the methods of data collection and analysis; and coherence, i.e. narrative truth or resonance.

Stiles (1993) and Elliott *et al.* (1999), in particular, have set out guidelines for carrying out good qualitative research in psychology, and this study will be assessed in relation to some of these criteria in the Discussion (Section 4). However, Barbour (2001) warns against an over-reliance on checklists for improving rigour in qualitative research. She maintains that these 'technical fixes' cannot confer rigour unless the principles of qualitative research have been applied systematically and thoroughly.

1.5.1.2 Generalisability

The concept of generalisability, which is used to show how representative an observation is, is a further aspect of reliability and validity, and considered to be important in quantitative research. The current study has a local and specific context, and like most qualitative research, does not aim to be generalisable. Nevertheless, the findings may be transferable to similar psychology or psychotherapy departments.

1.5.2 Grounded theory

There are different kinds of qualitative research but grounded theory is particularly suitable to investigate the proposed research question and is used here. A grounded theory methodology is increasingly being carried out in health care settings (e.g. Pope and Mays, 1999) and by clinical psychologists (e.g. Clegg, Standen, and Jones, 1996; Corrie and Callanan, 2001; King, 2001; McVey, Madill, and Fielding, 2001; Middle and Kennerley, 2001; Tweed and Salter, 2002).

Glaser and Strauss (1967) first laid down rigorous, systematic guidelines for grounded theory analysis. Later, Strauss and Corbin (1998) set out some procedural rules for grounded theory. Grounded theory's interpretative methods can be used to investigate subjective experience and processes (Charmaz, 1995). A grounded theory analysis is inductive, i.e. concepts and relationships are synthesised from the raw data using interpretations, which are then put together into an explanatory narrative. The research question is broad, open-ended and action-oriented and is answered by being 'grounded' in the data, i.e. the participants' responses (McLeod, 2001). The concepts are derived from the data and are not pre-conceived. There is a constant interplay or 'flip-flop' between the researcher's conceptualisations and the data (Pidgeon, 1996). As the researcher immerses

themselves in the data, meanings are made explicit. The technique of constant comparison is important in grounded theory analysis. Here, data, categories and concepts are continually compared so that similarities and differences can be found. Theoretical sampling is also used so that more data are added, e.g. through further interviews, if they can add to the data. Data collection and analysis are carried out simultaneously. Reflexivity on the part of the researcher means they are not left unchanged.

The data are analysed and interpreted by means of different kinds of coding whereby they are conceptualised and categorised in order to find overarching categories or themes that can describe the data and the phenomenon being investigated. Thus, a theme or themes are identified, and then an attempt is made to verify, confirm and qualify it by searching through the data. The theme that emerges from the data can be seen as the hypothesis (or theory).

2 Method

2.1 *Design*

A grounded theory design was chosen (Section 1.5). Data were collected through semi-structured, open-ended interviews (anonymised transcripts of which are available from the researcher). Apart from demographic and other quantifiable information from the participants, the interview schedule included five prompt questions around the topic of interest, and questions to bring about closure. The interviews were analysed according to grounded theory principles. The quality criteria on qualitative research in psychology of Stiles (1993) and Elliott, Fischer, and Rennie (1999) were followed as far as was possible, and Pope and Mays' (1999) questions were considered. This included checking the findings with feedback from the participants.

2.1.1 **Semi-structured interview**

This was in three parts (Appendix 1). First, the interview gathered information about the participants, i.e. how long they had been qualified, how many patients they usually saw in a week, and roughly how many they had seen for 26 or more sessions.

Second, was the open-ended part of the interview in which participants were invited to talk about the patients who had had a longer therapy. The prompt questions on the interview schedule illustrated the area of interest and asked about when participants decided to offer more sessions, and stop therapy; their reasons for offering more and the goals of therapy; and whether supervision or line managers had played a part in their decision. In practice

these questions were not asked in any particular order. Exact prompts were not used when participants spontaneously covered the material.

Thirdly, the interview was drawn to a close by inviting the participant to mention anything else, and by getting feedback about how they felt, and whether they would view anything differently as a result of the interview.

Participants were numbered in the order they were interviewed. Interviews took place over a four-month span: five were in the first month, three in the second month and the last in the fourth month.

2.1.2 Participants' feedback

As one check on the trustworthiness of the findings, about ten months after the interviews, the researcher sent a synopsis of the findings to the participants asking for their feedback.

2.2 Context and choice of department

The phenomenon of giving longer therapies probably occurs in many NHS psychology and psychotherapy departments. The department from which the participants for this study came was the one in which the researcher worked.

The Adult Mental Health Psychology Department, which has about 30 members, is part of an NHS Mental Health Trust and psychologists work in Community Mental Health Teams (CMHTs), as well as in tertiary psychology services, e.g. eating disorders, and with more complex patients. Most members carry out cognitive therapy whilst some also practise

cognitive-analytic and psychodynamic therapies. A wide range of patients is seen but those with psychosis were excluded from the study since treatment length guidelines applied differently to them. There is a focus on time-limited therapy and the department has long had a guideline of limiting therapy to around ten sessions. In practice, this guideline is not strictly adhered to.

2.3 Participants

Participants were qualified clinical or counselling psychologists who had seen at least one patient for 26 or more sessions.

Eleven psychologists volunteered to take part. One of these became a pilot while another had seen relevant patients in another Trust and was excluded. Since the sample included a wide range of experience, and included those working in tertiary services and in CMHTs, the number of participants seemed to be adequate. It was a convenience sample.

Participants were numbered 3 to 11, in sequence. Participant Number 1, the pilot interview, was excluded from the study. Participant Number 2 was excluded because the therapist had only seen longer-term patients in another Trust.

2.3.1 Participants' attributes

All participants, except one, were female; one was a Counselling Psychologist, the others being Clinical Psychologists. Table 2-1 shows that the participants covered a wide range in terms of the number of years they had been qualified, the number of their patients that had had a longer therapy, and the number of sessions they had given that were in excess of 26,

as well as overall percentages. Just over half of the participants (55%) had been qualified for less than 10 years, and 45% for over 10 years. More than half (56%) had seen fewer than 10 patients for 26 or more sessions; the rest had seen more than 10 patients for this long. Less than half the participants (44%) had given up to 50 sessions, while the remainder had given more – one participant giving more than 200 sessions.

Table 2-1 Quantitative information about the participants

Participant code number	Years qualified			No. of patients having 26 or more sessions		
	0-5	5-10	10+	0-10	10-20	20-30
3			✓	✓		
4		✓			✓	
5			✓			✓
6	✓			✓		
7		✓		✓		
8	✓			✓		
9		✓		✓		
10			✓			✓
11			✓		✓	
All participants	22%	33%	45%	56%	22%	22%

Participant code number	Maximum number of sessions given				
	26-30	30-50	50-100	100-200	200+
3			✓		
4			✓		
5					✓
6		✓			
7		✓			
8	✓				
9		✓			
10			✓		
11			✓		
All participants	11%	33%	44%	0%	11%

2.4 Procedure

2.4.1 Ethical considerations

The study was given ethical approval by the local Applied and Qualitative Research Ethics Committee (Appendix 2). There was managerial approval by the Clinical Director (Appendix 3), and confirmation of indemnity insurance by the Chief Executive of the Trust (Appendix 4). The ethics committee raised some issues to do with potential harm to the participants, role contamination, and anonymity. These were addressed before starting the study:

- The committee had assumed there was a policy in the department to limit therapy to ten sessions and that ‘going against the cost-effective policy’ could be harmful to the participants. In fact, this is a guideline not a rule. It is understood in the department that some patients will need more sessions and it is well-known that people, from the Head of Department down, have given more. Thus, potential harm was assumed to be unlikely.
- The researcher was not in a supervisory or line management role with any participant, therefore, there was no role contamination. The participants volunteered, after receiving information about the study, and were not personally approached about taking part.
- Anonymity was ensured by collecting as little identifying information as possible and then grouping it. All identifying information was removed from the transcripts. Only about one third from a department of about 30 people volunteered to take part, which further safeguarded anonymity.

Two further issues may also have had ethical implications. First, is whether there are disadvantages or benefits to the participants from taking part. It was thought that the department, and hence the participants, would stand to gain from the findings, especially if the outcome were some user-friendly recommendations. Second, is that the researcher knew the participants, some of them for many years. It was not known whether this would help or hinder how openly they would talk, but since participants had volunteered it was hoped that the problem would be minimal.

2.4.2 Recruitment of participants

A Preliminary Announcement (Appendix 5) and Information Leaflet (Appendix 6) explaining the purpose to the study and emphasising that participation was voluntary, and that contributions would not be identifiable but anonymous, were presented at a departmental meeting and sent out to members of the department in its weekly information sheet. Volunteers contacted the researcher and interviews were arranged for at least two weeks later, to give a cooling-off period during which they could withdraw from the study.

2.4.3 Interview

Participants signed a Consent Form (Appendix 7) before being interviewed and taped. Seven interviews took place in the researcher's office in the main psychology department, the other two at the participant's team base. Each interview took between 45 and 60 minutes. It was carried out in an open-ended conversational style.

2.4.4 Transcription of tapes

Tapes were transcribed and the transcriber signed a Confidentiality Form (Appendix 8).

The researcher then listened to all the tapes and filled in small sections of the transcripts that were inaudible to the transcriber. The transcripts were printed out and lines numbered.

Identifying information, such as names, were anonymised. Copies of these anonymised transcripts are available from the researcher.

2.5 Data analysis

The methods for this were derived from those suggested by Pidgeon and Henwood (1996) and Strauss and Corbin (1998). Two main techniques were used to code the data, and in the process of doing this, the researcher became immersed in the data. Firstly, data and categories were compared using constant comparison. For example, categories derived from one interview were compared to see if they could be combined. This process was also done with categories from different interviews, that is, between interviews. At the same time, there was iteration between the data and interpretation of the data, that is, in a repeating cycle, so that the interpretations were checked out. By these means categories became increasingly refined.

The analysis of the data took place while data collection was in progress (so that subsequent interviews could be influenced by previous ones). Although these processes are described as though they are linear and in discrete steps, in practice they take place in parallel, and the steps may merge.

2.5.1 Coding

Categories were first built up through the process of low-level, *open* coding. Each interview was coded and categorised separately. The categories from different interviews were then combined. They were combined using *axial* coding, and were interpreted, to find overarching categories or themes, using *selective* coding.

2.5.1.1 Open coding

For each interview, phrases and segments relevant to the topic were highlighted in the transcripts and copied onto record cards (together with line and interview number). These were the concepts. Cards were grouped into categories with common properties. Category labels were participants' quotes or the researcher's conceptualisations.

2.5.1.2 Axial coding

The categories were increasingly refined or revised by being grouped or split by the process of axial coding or category integration. This involved combining categories across interviews and it may be viewed as putting the jigsaw together (McLeod, 2001). These categories were listed on paper.

2.5.1.3 Selective coding

The higher level categories which had been discovered through axial coding were now integrated so that an overarching theme or themes could emerge.

2.5.2 Narrative

The findings were now summarised into an overarching narrative.

2.5.3 Memos

During the analytic process the researcher also wrote memos, containing thoughts and interpretations, to facilitate the development of categories.

2.5.4 Trustworthiness

2.5.4.1 Procedural trustworthiness

The researcher had an awareness of Stiles' (1993) criteria for procedural trustworthiness (Section 1.5.1.1).

2.5.4.2 Credibility checks

It was not possible, within the constraints of this study, to carry out all the credibility checks recommended by Stiles (1993), such as triangulation (in which the findings are compared with other data sources). The researcher was alert to how her thinking was affected by the material. Feedback was obtained in the following ways:

- Feedback from participants was sought in writing by asking the participants for their feedback on the findings. None replied to a detailed account of the findings, so they were sent a short 1½ page summary, to which all responded.

- Feedback from 6 psychologist readers of the findings, to see if the material was coherent and resonated with them.
- The researcher discussed the data and findings with two colleagues throughout the research process.
- A non-psychologist ‘auditor’ open-coded Transcript No. 6.

2.5.5 Researcher’s forestructure

The researcher is a long-established member of the psychology department being investigated and has known the participants, to varying extents and for differing lengths of time. She has worked in the tertiary psychology service for many years but did not join a Community Mental Health Team (apart from doing occasional sessions) until just before Participant No. 7’s interview. Although most of her clinical work is cognitive therapy, she also works cognitive-analytically and psychodynamically, and does not advocate that there is one best model of therapy. She has seen a few patients for a very long time, e.g. 200 sessions for a psychodynamic therapy and 100 sessions for a cognitive therapy, but is also comfortable doing very brief therapy, e.g. four sessions, when this seems appropriate. She is interested in audit and waiting lists.

3 Results

3.1 Introduction

Although the results are described as though they were arrived at in a linear fashion, it should be remembered that the analysis involved constant comparison across the data and categories, and a repeated process between interpreting and going back to the raw data. The abbreviations used in quotes are shown in Box 3-1.

Box 3-1 Abbreviations used in quotes

Transcripts are identified by their number, and line numbers,
e.g. 3/1-5 denotes lines one to five of Participant No. 3's transcript
... denotes short pause in the interview
[...] denotes material from the transcript has been omitted

3.2 Coding

3.2.1 Open coding

First, each transcript was coded separately. *Concepts* were identified from segments (usually in the form of short phrases) of the text and given concept labels, in the participants' or researcher's words, to reflect their meaning. For example, the segment of bold text in the following extract was given the concept label 'hard to finish':

6/27-28 [...] they still had ongoing problems that they were struggling with that made it **hard to finish** sessions [...].

The concepts from each interview were then clustered together into *categories*, by looking for similarities. For example, in Participant No. 6's transcript (Appendix 9), the following concepts, relating to the therapist's difficulty in stopping therapy, were combined to form the category 'Hard to finish', the label being retained in this instance (Box 3-2).

Box 3-2 Concepts forming the category 'Hard to finish', for Participant No. 6

I find it difficult to discharge people who are anxious about being discharged
Because she was very low weight, therefore, very difficult to pull out
I was taking account of their symptoms
I was responding to their anxiety between sessions
Patients were anxious about ending the sessions
If long-term therapy, danger of dependency
[Difficult to carry on] because of the waiting list and breaking rules in some way
Above 20, I think, is this OK?
Ongoing problems made it harder to finish

A complete list of categories for each interview is shown in Appendix 10. There were between seven and 25 categories per interview, each category having been constructed from between two to 25 concepts. For example, for Participant No. 6's transcript, there were another six categories in addition to the category 'Hard to finish' (Box 3-3).

Box 3-3 All categories for Participant No. 6

Discussion in supervision/line management
Review – how to decide
Mixed feelings (re continuing or ending). Indecision
Carry on/difficult to stop
Hard to finish
Reasons for stopping
Type of patient

3.2.2 Axial coding

During axial coding, the categories from all transcripts were examined for relationships (e.g. similarities) so that categories could be combined and refined. At the same time, the researcher continued checking that the categories fitted with the raw data. Each category, derived by open coding from the individual transcripts, was then subsumed within a higher order, combined category across the transcripts. This produced a list of 23 *combined categories* across the participants (Box 3-4).

Box 3-4 Combined categories for all participants

Pressure from others (to take on or succeed)
Type of patient
Reasons for taking on
No hard and fast rules
Goals and aims of therapy
Contracting
Engagement/trust
Reasons for offering more
Difficult to stop
Reviews
Reasons for stopping
Sometimes have to stop
Give up
Failures
Role
Therapy versus maintenance
Being demanded of
Carrying a burden
Doubting
Painful awakening
Justifying what one does
Getting something out of it
Learning

To illustrate the process, all the categories for Participant No. 6 were subsumed into four of the combined categories, as shown in Table 3-1.

Table 3-1 The combined categories under which Participant No. 6's categories were subsumed

Participant No. 6's categories	Combined categories for all participants
Discussion in supervision/line management Mixed feelings (re continuing or ending). Indecision Carry on/difficult to stop Hard to finish	Difficult to stop
Review – how to decide	Reviews
Reasons for stopping	Reasons for stopping
Type of patient	Type of patient

The relationship between categories was elaborated and clarified further through forming links between them that could be used to explain certain phenomena such as different stages of therapy. The nine categories that emerged are shown in Table 3-2.

Table 3-2 Categories, derived from the combined categories, by axial coding

Combined categories derived from open coding	Categories derived from axial coding
Pressure from others (to take on or succeed) Type of patient Reasons for taking on No hard and fast rules	1. Taking the patient on: 'No hard and fast rules' about who is taken on
Goals and aims of therapy Contracting Engagement/trust	2. Starting therapy: 'Starting with a trial run'
Reasons for offering more Difficult to stop	3. Offering more sessions: 'It doesn't seem sensible to cut out half the tumour' but 'Not within the spirit of what we should be doing'
Reviews	4. Reviews: 'Considering the options'
Reasons for stopping	5. Stopping therapy: 'Gained enough' or 'Shutting up shop'
Role Therapy versus maintenance	6. Trying to be a good psychologist: While 'putting them back together again quickly'
Being demanded of Carrying a burden	7. Carrying a burden: Trying to 'make amends' and Being 'set up'
Doubting Painful awakening	8. 'Painful awakening to reality': There has been a 'learning process'
Justifying what one does Getting something out of it Learning	9. Managing self-esteem: 'Relative imperviousness to pessimism' and 'A sense of humility'

There was material relating to most categories in each transcript, especially for categories 1 to 5 (Appendix 10). However, some categories were not derived from every transcript. Table 3-3 shows the categories that were derived from each participant's transcript (✓ denoting the presence of material relevant to each category).

Table 3-3 Who said what (axial coding categories derived from each participant)

Participant code number	Axial coding categories								
	1	2	3	4	5	6	7	8	9
3	✓		✓				✓		✓
4	✓	✓	✓	✓	✓		✓		
5	✓	✓	✓	✓	✓	✓	✓		✓
6	✓	✓	✓	✓	✓				
7	✓	✓	✓		✓	✓	✓		
8	✓	✓	✓	✓	✓	✓	✓	✓	✓
9	✓	✓	✓	✓	✓	✓	✓	✓	✓
10	✓	✓	✓	✓	✓	✓	✓		✓
11	✓	✓	✓	✓	✓	✓	✓	✓	✓

Key for axial coding categories:

1. Taking the patient on
2. Starting therapy
3. Offering more sessions
4. Reviews
5. Stopping therapy
6. Trying to be a good psychologist
7. Carrying a burden
8. Painful awakening to reality
9. Managing self-esteem

3.2.3 Selective coding

The process of selective coding now took place in that the nine categories derived from axial coding were integrated to find an *overarching category* that could explain the topic of the study. From this, the overarching category '*going through the stages of therapy while balancing competing demands*' emerged (Table 3-3). It comprised two themes – going through the stages of therapy; and balancing competing demands.

Table 3-4 Overarching categories, derived from axial-coding-categories, by selective coding

Categories derived from axial coding	Overarching categories derived from selective coding
1. Taking the patient on: 'No hard and fast rules' about who is taken on	A. The stages of therapy: 'Breaking the rules in some way'
2. Starting therapy: 'Starting with a trial run'	
3. Offering more sessions: 'It doesn't seem sensible to cut out half the tumour' but 'Not within the spirit of what we should be doing'	
4. Reviews: 'Considering the options'	
5. Stopping therapy: 'Gained enough' or 'Shutting up shop'	
6. Trying to be a good psychologist: While 'putting them back together again quickly'	B. Balancing competing demands
7. Carrying a burden: Trying to 'make amends' and Being 'set up'	
8. 'Painful awakening to reality': There has been a 'learning process'	

Categories derived from axial coding	Overarching categories derived from selective coding
9. Managing self-esteem: 'Relative imperviousness to pessimism' and 'A sense of humility'	

3.2.4 Memo-writing

During the analysis of the interviews, the researcher jotted down thoughts of anything that might help with the analysis, in the form of memos and a diary. Presenting extracts here is an example of procedural trustworthiness, showing the researcher’s reflexivity and giving evidence to other readers. Samples of memos relating to three transcripts are reproduced in Appendix 11. An extract from the memo written while coding the transcript of Participant No. 6 follows:

The impression I have is of people really putting themselves out for their patients. There may be a satisfaction for oneself from that, but the patient’s well-being definitely comes first. Therapists are doing something against the odds. That, despite the pressures, therapists try to do a good job, not just a pragmatic job. And that they are really helping people when they do this (on the whole). This should be valued – people shouldn’t have to feel bad about this (and keep it a secret), as some seem to do.

3.3 The findings: Going through the stages of therapy while balancing competing demands

The following is a description of the content of the nine main categories that emerged from the coding process. The categories are illustrated with quotes from the data to confirm their trustworthiness.

3.3.1 Going through the stages of therapy: ‘Breaking the rules in some way’ (6/62)

3.3.1.1 Taking the patient on: ‘No hard and fast rules’ about who is taken on (4/485)

Few patients in the psychology department have a therapy of more than 20 sessions (Westbrook, 1999). This study focuses on a very small but important minority of patients. All participants, except Participant No. 6, gave more sessions to patients with complex, long-standing problems. This included those who had had multiple childhood traumas. They often had interpersonal problems. The patients might have had much previous treatment, including hospitalisation, and could be at risk of self-harm or suicide. In addition, they could be severely depressed or have various anxiety disorders including Obsessive Compulsive Disorder, Post Traumatic Stress Disorder, and eating disorders. Participant No. 6 said they gave more sessions to patients who had severe problems such as depression and agoraphobia, rather than those with personality disorders. Patients with psychosis were excluded from the study (Section 2.2).

There are no 'hard and fast rules' (4/485) about taking patients on. It cannot be predicted at the outset, or even at later stages, who is likely to receive and benefit from a longer therapy, or what the exact number of sessions will be. This may be because the severity of the problems may not be known, or how the patient will respond to therapy:

10/42-44 And often of course there's...not infrequently the case you start off with isn't the case you finish up with. They either divulge, or other circumstances reveal maybe greater pathology than you first thought.

The psychologist may be the only one in the multidisciplinary team who can offer them therapy but this reduces demands on the service as a whole (7/421-423), or otherwise may have little choice about taking a patient on:

10/9-18 So, sometimes you might handle people that can maybe go elsewhere in a larger set-up. [...] ...more and more severe particularly so-called personality disorder patients are getting referred to our service, and often then finish with me.

Thus, there are many individual reasons for taking on a patient for a longer therapy, and no hard and fast rules about it.

3.3.1.2 Starting therapy: 'Starting with a trial run' (11/10-11)

Psychologists see their role as facilitating change. Therefore it is important that the patient should be able to use therapy, and change, even if only minimally. It is expected that it may take time to engage and have a constructive therapeutic relationship with the patient who needs more sessions. Testing out these factors also takes time and may involve frequent reviews. Because of these uncertainties, therapy is often started with a 'trial run' of a few

sessions to see if the patient will respond (5/135-139), which, if successful, will allow therapy to continue:

11/8-12 The kinds of people who I take on are, and who are referred to me, are nearly always people with very complex longstanding problems, who have had lots of previous treatment. The intention is, in some cases, to start with a trial run to see if they will respond to cognitive therapy, and in practice, most of them show some signs of responding, and so one continues with them.

Goals can vary from extremely modest such as helping someone to function at a basic level, to more profound change.

10/201-204 I mean I think one has variable targets according to the person and their circumstances. I'm working with a chap just now who I have known for almost five years, and who was an inpatient for two and a half years, and my ambition for him is to get him able to go and take his dog out [...]

3.3.1.3 Offering more sessions: 'It doesn't seem sensible to cut out half the tumour' (10/25) but 'Not within the spirit of what we should be doing' (3/175-176)

The heart of this research is about why therapists offer more sessions, particularly when there seem to be many factors against doing so. External pressures, including departmental guidelines, are forces towards keeping therapy brief. Offering one patient more sessions means others lose out because the waiting list becomes longer. But psychologists may resist these pressures and give more sessions.

These reasons may be because the patient is making progress. The psychologist continues therapy, possibly to try and reach the goal and do therapy 'properly' (11/169; 4/157-161; 5/223-228) and because 'it doesn't seem sensible to cut out half the tumour' (10/25).

Paradoxically, therapy may continue because of a lack of progress. Early impressions of the patient may have been mistaken when they do not make the hoped-for progress. Then the therapist may offer more sessions in the hope that progress can still be made or because of the patient's ongoing problems:

4/204-205 ... she in fact was not psychologically minded, and I kept thinking that she could be, ...

8/351-352 And that I just kept, kept on going and going and going, thinking, surely something is going to make a difference to your mood, and... .

Therapy may continue because it follows a 'lengthy, erratic course' (10/32) or shows 'fluctuating movement':

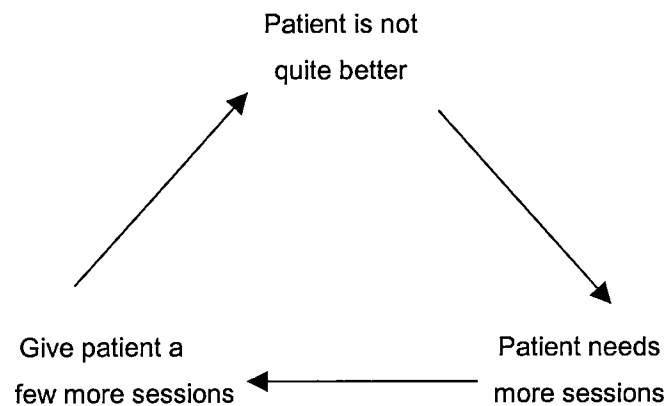
11/86-89 The people I go on with are likely to be the people who engage well in the end, and with whom I have the sense that there really is some potential for change, or genuine movement, of fluctuating movement, so that they make gains and then lose them.

The therapist may fear that the patient could deteriorate or die (10/30-32) or the patient may have crises:

6/159-162 And I think because she was very low weight it was very difficult to pull out, because of the risks of deteriorating, and she was very anxious about that as well, so that's why we sort of continued, and she's made steady progress.

The examples above could be understood as the therapist getting into a vicious circle with a partial reinforcement effect (Figure 3-1).

Figure 3-1 Vicious circle showing a partial reinforcement effect



As therapy comes to an end the therapist may want to have a proper, planned ending, which then means having more sessions:

4/79-80 ... we had to have a very planned end, and that meant stating something that was reasonable, which wasn't just two sessions from then. So that's how it ended up with there being thirty, [...]

However, the patient may have an adverse reaction to a proposed ending. This could be to do with the patient's attachment to the therapist:

8/509 [pause] A lot, a lot of crying at any sign of ending.

3/69-71 ... the main reason why I'm carrying on seeing him, but the main reason is that he has become very attached to me, and that attachment in some sense is useful for keeping him alive.

Other professionals, the patient or their family, may pressure or flatter the therapist into continuing:

7/485-488 But there was a real resistance from people outside of the Health Service, from the Social Services Department not to pull out, you know, pull back on the therapy. Although actually the goals that she had identified weren't workable really.

8/247 And there was a CPN who had particularly said, he must have T. [participant], [...]

Five of these therapists are relatively unaccustomed to working in a longer-term way and thus may lose therapeutic focus and drift. Drift may come about when the therapist stops reviewing (with the patient or supervisor). It is as though the therapist loses their self-critical capacity. The therapy 'takes on a life of its own':

8/76-80 Then it sort of rolled on a bit I think for another, another ten sessions. I think in a way, the last sixteen sessions probably, or the last ten sessions, [pause] [...] The whole thing seemed to take on a life of its own in a way, so...

11/246-249 I think I haven't been clear enough about what I'm doing, and I've allowed myself to drift, and be what I...excused myself, and I've drifted by saying it's creative and interesting. (laughs) But I think sometimes it hasn't been.

Discussing the therapy with someone, such as a supervisor, line manager or colleague (11/152; 3/317-327), can stop drift and bring about a resolution but in the absence of an explicit suggestion to stop, the therapist may still continue:

6/226-227 In the absence of somebody saying, you know, what about discharging this person, I think I'm more likely to carry on.

The therapist may stop telling their supervisor about the patient:

8/473-474 [...] *the funny thing is, I didn't really discuss it with him. In some ways I...I wonder if it was sort of a bit of a secret.*

3.3.1.4 Reviews: 'Considering the options' (6/180)

Reviews are intended to be the means by which therapy stops, and they may be overt or implicit. Although not every participant mentioned reviews, they were implicit in their material. Reviews can occur at any stage of the therapy process. Interestingly, reviews can also have less overt functions and can be a means of intentionally extending therapy (as mentioned in Section 3.3.1.3):

6/29-30 *I think with all those people I did sort of take it five sessions at a time, but just kept going.*

At other times the reviews do not seem to have fulfilled their function:

6/247-249 *Some people when you have a review, it really does feel like you are deciding whether to continue or not, with other people, I think there's a sort of assumption, you're going to continue but let's just check it out and think about it.*

3.3.1.5 Stopping therapy: 'Gained enough' (11/482) or 'Shutting up shop' (10/257)

Despite all the difficulties mentioned above, therapy does stop, i.e. the therapist does reach a point of negotiating an ending. Just as more sessions may be offered because therapy may or may not be going well, so therapy may stop for these same reasons, that is, because it is going well, or badly:

11/481-482 *In most cases they just feel they've gained enough for the time being.*

10/256-258 [...] if it seems they're not getting anywhere, then you sort of shut up shop on that particular individual, or you'd just be plugging away mindlessly.

This judgement itself can change, in that a modification of the goals may transform a therapy from failure to (comparative) success, and so make termination easier. For example, if the goal was to produce change in the patient but this does not succeed, then changing the goal to, say, producing a clear formulation of the problems so that the patient can gain understanding, will produce 'success'.

There seems to be conflict between viewing a longer therapy as helping a patient towards independent functioning while, at the same time, being concerned that the increasing number of sessions could be encouraging dependence. It may be easier to make the decision to stop because one does not want to foster dependency:

11/305-309 So I'm very aware of the possibility of encouraging too much dependency and working always towards fostering somebody's independence and ability to make choices and decisions that are functional for them. And as people do that, it would certainly come to my mind, now is the time to stop,[...]

It is easier for the therapist to stop if external factors leave them no choice, e.g. leaving the team (4/39-40) or going on maternity leave (9/97-98). Similarly, it may be easier if the patient decides to finish (4/46-47; 6/74-78) or leaves:

5/252-257 ... I'm just finishing with a patient who I've seen for 117 sessions, and she happens to be moving... [...] I think I would have found it really difficult to end with her if she wasn't going to F, even though intellectually I know this is probably the right time for her to move on.

It seems as if stopping may be a more difficult decision for the psychologist to make on their own unless they have others to help them. For example, the line manager, supervisor, colleague, the team or the patient's family, can help the therapist stop now, rather than continue:

4/59-63 And, and I just kept thinking that it would help, (laughs) and it could help, and that we were making progress, but actually, we weren't. (laughs) And, we got to thirty sessions, just we, I decided on discussion with Y. [line manager] that I really had to end, that she wasn't going to be able to benefit from it, and she'd had a fair go, it wasn't making any difference.

3.3.2 Balancing competing demands

This theme is exemplified here:

9/445-448 [...] the thrust of the moment seems to be about reducing wait times. And I'm sure that if one was to expand on that, it's reducing wait times, yet offering people a high quality service, but sometimes I think that's quite difficult to do with people who have got very longstanding complex needs.

3.3.2.1 Trying to be a good psychologist: While 'putting them back together again quickly' (3/139)

The participants are trying to function as good psychologists according to what they perceive are the criteria of their training:

9/549-551 ... I was still in the sort of slightly idealised role of...the role of the psychologist is to enable people to help themselves, and we shouldn't be sort of pressurised to do that in x number of sessions.

The participants see themselves mainly as cognitive therapists and have an expectation that the patient will change and improve their functioning during therapy rather than working on maintaining a patient's functioning (11/203-206). Because of this, the psychologist resists taking on a more monitoring role:

7/320-325 And I wouldn't carry on...although I talked about key working, I don't think I would carry on seeing somebody as their key worker unless I thought that it needed a psychologist to be doing this work, [...]. I wouldn't take somebody on for maintenance long-term, if I thought that somebody else within the team could be doing that.

Fulfilling the role of the psychologist may be difficult to achieve when there is pressure (coming from outside but, maybe, also from oneself) to give as few sessions as possible (9/445-446), which can set up conflict and dissatisfaction:

3/137-140 ...also I think, I was getting very disheartened in the kind of patient-bashing kind of way of working, by which I mean seeing a lot of people really fast, putting them back together again quickly, to some level of functioning, and then discharging them, without ever feeling that you've done a really thorough job.

3.3.2.2 Carrying a burden: Trying to 'make amends' (3/196) and Being 'set up' (11/551)

Working with the patients who are offered more sessions can be difficult and burdensome:

10/86-89 Other clinical psychologists I've had working with me, they've either been relatively young or inexperienced, and one has felt that whilst their technical personal knowledge may be more than adequate for the job, sometimes a burden of coping with suicide people is not something you want to rest on their shoulders, so you carry that lot.

In addition, there are external and internal pressures on the therapist. As already mentioned, others (the team, the patient or their family and other professionals) may make demands of the therapist. These may range from expecting the impossible miracle cure to denigrating what the psychologist is doing, so making it harder to feel valued:

11/543-552 [...] there is sometimes the opposite when somebody starts talking about things, you can't stop them and they get fantastically distressed, and provoke crises in their lives, and then people say it's all you cognitive therapists making them worse, and you shouldn't do it. [...] people hold on to somebody who's in crisis, saying, 'Eventually the psychologist will see you. And then, they'll deal with it, and it'll all be better.' And one's, you know, set up to be the person who's going to change a situation which is probably impossible to change.

The therapists have a great sense of responsibility towards their patients, and have empathy for them. The psychologist may want to make amends for previous failed interventions (3/193-196) or the patient's adverse life circumstances:

9/220-222 [...] the emotional thing for me that kept me wanting to really help this person was that, he was actually a really, really nice person, and he had so much potential, and his life was so sad, and so unfair. It was actually quite distressing.

3.3.2.3 'Painful awakening to reality' (9/421): There has been a 'learning process' (9/564-565)

Through the processes of gaining experience in the job, and of trying to do ones best with these complex cases, there may be a 'painful awakening to reality' (9/421) that one cannot do enough for all ones patients:

9/419-422 When I'm relating it to you now, some of it feels like, that a lack of experience played a role, and perhaps a lack of awareness about the pressure on services. It's almost like a sort of, painful awakening to the reality of what we can actually do, [...]

The psychologist may feel guilty at the realisation that some patients may get a better service than others because some patients with long-standing complex needs will have a brief intervention which is unlikely to fulfil their needs (3/222-225). The psychologist may doubt the quality of the therapy they offer and have misgivings about its length. They may feel shame or guilt, and believe that they should do better:

8/577-578 Because I tend to think, oh my god! it's so terrible to have so many sessions, you know. The ultimate therapist is the one who can do things in three sessions or less.

11/571-572 ... I never feel sure that I'm actually providing therapy properly or right.

These issues are particularly pertinent for the more junior psychologists, and those who work in CMHTs. There is frustration at being unable to do what one would really want to do, such as get a patient significantly better regardless of how long this takes (9/299-300). As they go through their career they may become more aware of the waiting list and the thrust to keep therapy brief, and may feel they have to work within shorter time-limits:

9/426-433 ...what I'm now faced with is, when I look at the wait list, and I see people with complex, very long-term problems, I sort of feel a bit of a heart sink, what can we do with this patient in ten sessions? Not a lot. Therefore, what can we offer them really? There's been a complete shift in my mind as to, what can I do to help this patient, what can I do to help this patient help themselves, as to, how on earth are we going to get this patient through the wait list quickly? How on earth are we going to get them functioning with the limited number of sessions that we're able to offer? So it's more of a...it's more of a cognitive shift on my part now.

The psychologist learns with increasing experience but it does not seem enough:

8/213-214 As you sort of learn more and more, you become more, I do, become more and more aware of how little you do actually know.

3.3.2.4 Managing self-esteem: 'Relative imperviousness to pessimism' (11/614-615) and 'A sense of humility' (11/369)

It seems that the psychologists interviewed for this study were sometimes at something of an impasse about providing what they thought they should be providing, in the way they thought best. They had to find a way of balancing these conflicting pressures while being able to continue doing their work without burning out. Being able to justify the longer therapies they had given was important in preserving their self-esteem and self-respect:

3/170-176 So out of that work I have done a lot of thinking, and clear planning, of how I can make treatment shorter, but it's still not very short, I'm offering now thirty sessions, but how I can make treatment shorter. So I think, I've tried to use it as almost a kind of form of CPD for me as a test for doing something that might actually be very useful, I'm not sure. And that was I think my way of justifying doing something that I know is not with...within the spirit of what we should be doing.

The many satisfactions gained from doing this longer-term therapy (e.g. exercising the 'proper' role of the psychologist; having more opportunity of getting someone better; having a more grateful patient) can compensate for the difficulties (11/610-615). The therapists learn and change as they do their work, and find it rewarding:

10/180-182 But, there are needy people, and it's very pleasant when they go out the door smiling. I find that rewarding, and that overlaps with my job responsibility.

However, one aspect of the enduring dilemma is summed up as follows:

6/61-64 I think it's more this expectation that we can only offer very short-term treatment given the waiting list we have, and, [pause], breaking the rules in some way. I think it's like I'm still struggling with those issues really. When you see somebody for thirty sessions, it does have a look of... It's quite difficult.

3.4 Narrative

The content and relationships between the two themes of the overarching category can be summarised as a short narrative, as follows:

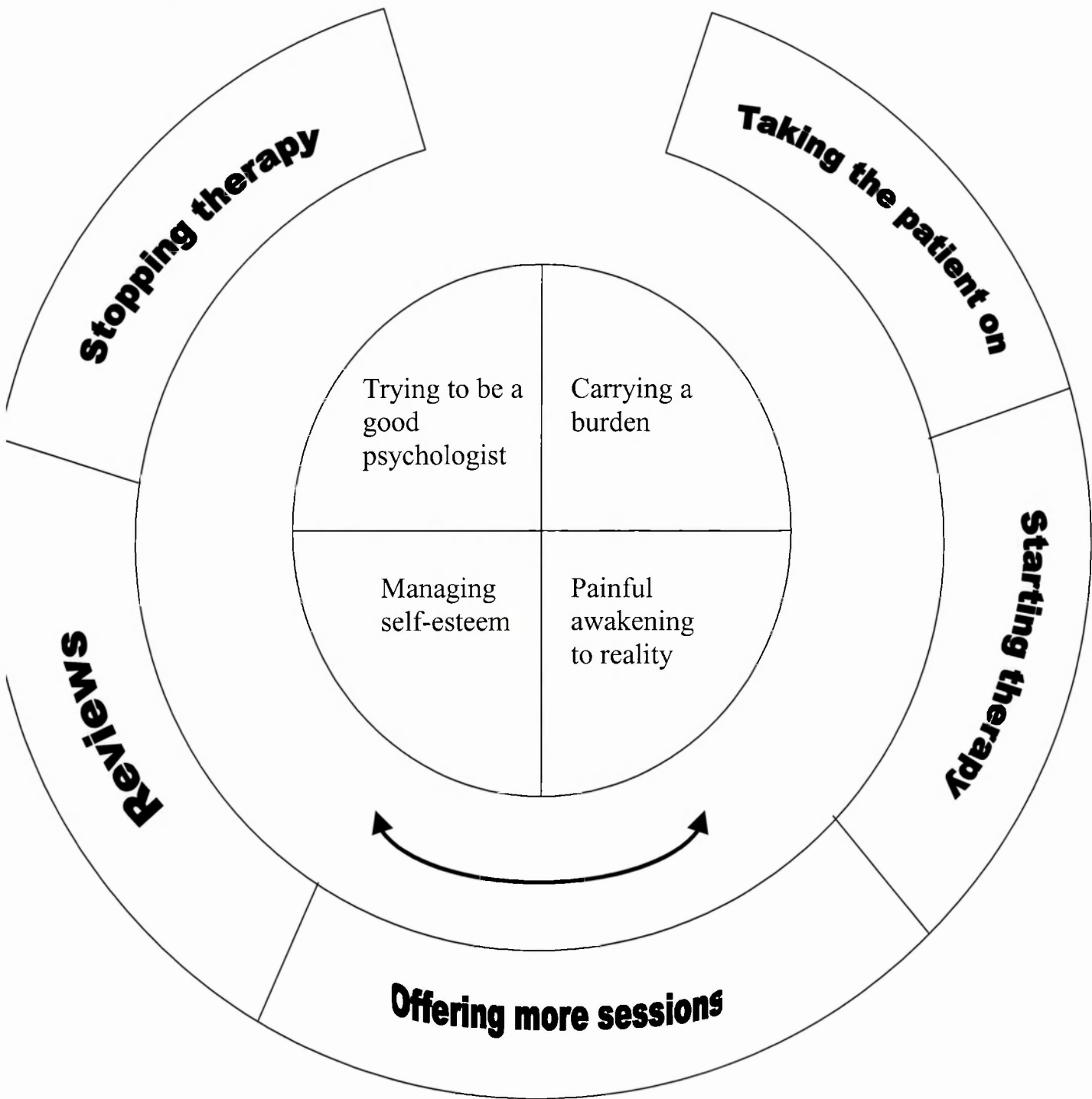
First, participants describe the stages of therapy taken with the patients they see for longer. The psychologist may make decisions, for example, about offering more sessions or about finishing therapy, at any stage of therapy. These decisions may be revoked or modified, often during reviews, so that the stages may not form a linear sequence. Although the therapist is usually trying to keep the therapy time-limited and focused, therapy becomes extended. This may be seen as 'breaking the rules in some way' (6/62) and can give rise to a conflict between wanting to continue and reaching a satisfactory goal, yet feeling one ought to stop because of the external pressures to keep therapy brief. However, it seems that, once extended, therapy often continues. This may be because therapy drifts but can also be because of the patient's crises, or the therapist's attempts to keep the patient alive. Although reviews are carried out, they may not immediately lead to termination of therapy: planning an ending may lead to more sessions. Therapists may stop discussing the therapy with their line manager, as though it has become a secret. Eventually, they may seek advice from a colleague to either help them stop or give them permission to continue.

Second, the competing demands experienced by the participants underpin the themes. There is a difficult balancing act to maintain between the following conflicts – doing their best for the patients (which may not be enough); complying with the demands of the setting; and trying to fulfil the role they were trained for. The participants try to negotiate their way through the, possibly unrealistic, expectations of others and want to make it up to people who may have had bad earlier experiences. These pressures, and those they put on themselves to be responsible, place a burden on them.

The pressures may be experienced slightly differently within different types of team or setting, and over time (i.e. with increasing experience). The pressures towards 'putting them back together quickly' (3/139) may be greater in a Community Mental Health Team (CMHT) than in tertiary services. A newly qualified psychologist may be less aware of the waiting list, and so feel less constrained about the number of sessions they offer (9/420-421). As they gain experience there is the 'painful awakening to reality' (9/421), i.e. the realisation that therapy should be brief, if possible, and that one probably cannot do enough for the patient, given the waiting list and pressure of referrals. When the psychologist gives someone more sessions they may think this reflects their lack of skill (8/577-578). Therapists often realise how much there is still to learn (8/213-214). They can feel shame and doubt, and even very experienced psychologists may have uncertainties about whether their work is good enough (11/571-572). But the psychologists go on working hard and creatively, for many years, and have to find ways of coping with these stresses and keeping up their self-esteem. They are able to justify what they do, and get something positive out of their work, although it may be difficult to bring these feelings into the open and share them with others.

The findings may be visualised as a disc surrounded by a broken circle (Figure 3-2). The central disc represents the four 'demands' while the broken circle represents the five stages of therapy. The disc can turn independently of the circle, which remains stationary. Thus, if the disc were to spin and then stop (like a roulette wheel), each of the four demands could come to rest opposite any of the five stages of therapy. This demonstrates how any of the demands can occur during any stage of therapy. For example, 'Trying to be a good psychologist' could face 'Stopping therapy', as on the diagram, showing that this demand can affect that stage of therapy. But, after the disc has spun round, 'Trying to be a good psychologist' could also stop opposite any of the other stages of therapy, and thus affect those stages. In other words, the competing demands can apply to any (or all) stage of therapy.

Figure 3-2 The two themes



3.5 Credibility checks

Credibility checks were carried out, which entailed getting people's responses to the interviews and to the written findings.

3.5.1 Effect of the interview on the participants

At the end of the interview participants were asked how being interviewed had affected them (Appendix 12), and whether they would see anything differently now (Appendix 13). They said they had felt 'fine' about being interviewed.

In response to the second question, three participants said they had already started to make changes (i.e. carry out reviews; acknowledging it had been a mistake to take one of the patients on; and being clearer about setting session limits). The future actions mentioned referred to all stages of the therapy process. These were – being more overt about who to take on; making contracts; reviewing; checking out case management with someone else; and how to end. The remaining participant wanted to think about guilt because it was a question they hadn't been able to answer.

One participant was concerned about being identified. The researcher had also become aware of this during the interview and had felt uncomfortable. After the interview had finished the participant then revealed more information about their feelings (see Appendix 14 for the researcher's memo about her responses to this). The researcher could not ethically use this information.

3.5.2 Respondent credibility checks

This was an important means of checking the credibility of the findings. After getting almost no response to a detailed report of the findings, a short synopsis of the findings was sent to the participants to see whether it resonated with them, and whether they wanted to add anything. All participants replied and details of their feedback is in Appendix 15. They were broadly in agreement with the findings, e.g. ‘This seems a fair summary. I don’t think that I personally raised issues in all the categories but they seem reasonable. I can’t see that you’ve left anything out’ (Participant No. 4). Participant No. 11 felt that there was too much emphasis on conflicts and not enough on positives, while others said that they had not experienced all the issues mentioned. Participant No. 5 commented that ‘therapy should be brief – if possible – but a recognition that some individuals will require longer. I guess it is about recognising one’s limitations.’ Participant No. 7 added that ‘other difficulties in CMHTs include keeping people on because others are burdened, or you feel (arrogantly) that there’s no one else to see them.’ Participant No. 9 thought that ‘there are some general rules [about taking the patient on], but not when it comes to extending. It’s not always clear, no consensus amongst department.’ In the context of managing conflict, Participant No. 10 thought that there should be ‘recognition that therapy should be briefer rather than brief.’ Participant No. 8 said ‘... a few months down the line – and with more experience, I think I would think differently about things now and do things slightly differently.’ Participant No. 8 added,

[...] as I have gained more experience, particularly with complex cases, I tend to be better at dealing with things like crises at every session. [...] And, maybe it’s negative, I have perhaps become a bit “harder” – tending perhaps to think more quickly – if there is very little sign of progress perhaps we should stop.

The researcher made sure the points raised were covered in the findings.

3.5.3 Readers

Six psychologists (five from the department in question and one from another) read drafts of the dissertation and thought that the findings made sense to them.

In addition, two psychologist colleagues gave critical and constructive feedback during the whole research process, including on the evolution of the emerging categories. By discussing agreements and disagreements, their alternative perspectives facilitated the researcher in refining the categories.

3.5.4 Auditor

The auditor open-coded Transcript No. 6 after reading two other transcripts and the detailed results. The auditor had the researcher's list of categories for that transcript. They came up with 28 categories, 15 (54%) of which approximated to the researcher's. The large number of categories suggested that the list was at a 'lower' level of coding than that of the researcher's seven rather similar categories for that transcript.

4 Discussion

4.1 *Aims of the study*

The study attempted to explore the reasons why a small sample of psychologists gave longer therapies, so that ways could be suggested of shortening longer therapies, should this be appropriate. The research also contributes towards understanding therapists' decision-making when they have to deal with conflicting demands.

4.2 *Summary of the findings*

Two related themes emerged from the analysis of the data: the stages that therapy goes through during which it becomes extended, and balancing competing demands while carrying out the therapy.

Therapists encounter various problems, which result in therapy becoming extended. Therapy may become extended because of factors related to the patient, such as the patient going through a crisis, or through others putting pressure on the therapist to continue. In addition to this, and importantly, it seems that the therapist sometimes finds it difficult to stop therapy, even when they review frequently; and that, once over the ten-session guideline, it is almost as if the guideline no longer applies. Therapists may stop informing their supervisor or line manager about what they are doing and it is as though the therapy becomes a secret. However, when they find it difficult to stop, the therapist may ask a colleague for advice, to make the decision to help them draw therapy to a close.

The degree of the demands on the therapist varies with the kind of team in which they work, and with their experience. These demands give rise to conflicts, which are not easily resolved. The demands can result in the therapist feeling burdened, unable to fulfil the role of psychologist as they would wish to, and unable to do as much for the patient as they would like. This may result in the psychologist having doubts about their work.

Nevertheless, they can justify what they have done, and often get satisfaction from doing longer-term therapy with the patients. Despite the conflicts, they may be able to maintain their self-esteem, although this may not be shown openly. However, the dilemma about going against the prevailing culture persists.

4.3 Discussion of the findings

There is an expectation in the psychology department, and the wider system of the CMHT, that therapy should be brief, and the department has had a guideline for some years recommending that therapy be kept within ten sessions. Despite this, the participants gave longer therapies to a few patients.

The two main themes describe problems encountered by the therapists which arise from their conflict between keeping therapy brief and extending it. The conflicts from the first theme may be to do with the patient (such as, the patient being worse than originally thought, or the patient not making progress); or may be to do with others (for example, pressure from other professionals to go on seeing the patient). From the second theme, the conflicting demands on the therapist may result in self-doubt and keeping the therapy secret.

The outcome of these conflicts is that therapy continues and may be difficult to stop. This may not be the best outcome because the therapy has gone on for too long and resources are

wasted. It is possible that the therapists' decision-making could be improved, if they could be helped to stop therapy sooner. This might necessitate a more open culture, where problems and behaviour could be discussed openly. Recommendations for change are discussed in Section 4.6.1.

4.4 *Methodological issues*

4.4.1 Design of the study

In the Introduction (Section 1.5) the case was made that, in order to answer the research question and since there was no predetermined hypothesis, a qualitative research design based upon grounded theory was more appropriate for the study than a quantitative design. The value of this was demonstrated when the researcher's preconceptions and ideas about why longer therapies are given were found to be insufficient and to lack the variation given by the participants. Talking to the participants in an open-ended interview gave richer information which was unlikely to be gained in another way.

4.4.1.1 Alternative designs

It is possible that the research question could have been answered in a quantitative way by using a questionnaire. If this had been done, then the sample could have included therapists from other departments, to make the results more generalisable. However, such a questionnaire is not available and would have to be designed. This would have necessitated an open-ended qualitative pilot study – such as the current study.

4.4.1.2 Data collection and analysis

Data collection and analysis take place simultaneously in qualitative research, and should be as transparent as possible so that readers can judge how the conclusions have been drawn.

The researcher should therefore present a clear account of the whole process as was, hopefully, done in the Method and Results Sections.

However, with hindsight, the researcher realised that she could have been more flexible in developing the interviews as she went from one to the next, by paying more attention to what earlier interviewees had said. She could also have been more probing with her questions and asked the interviewees to supply more detail. However, she considers that the information obtained was still sufficient to answer the research question.

The researcher may have lost focus in some interviews by not asking all the prompt questions. Although this could be seen as a limitation, it meant that rich data were obtained by allowing the interview to take on a life of its own. The researcher's impression was that a loss of focus did not result in useless information being collected, rather, that the data were richer.

4.4.2 Procedural trustworthiness

Stiles' (1993) term, procedural trustworthiness, refers to ways of establishing some kind of repeatability of the findings by giving others enough evidence to draw their own conclusions (which could be agreeing with the findings or suggesting alternatives).

4.4.2.1 Owning one's perspective

The position of the researcher at the start of the study was stated in the Researcher's Forestructure (Section 2.5.5). Her position changed during the course of the project in that it made her consider the value of reviewing more frequently herself and setting more concrete goals in future. Some of the researcher's responses to the data have been alluded to in the memo for Participant No. 6 (Section 3.2.4) and in Appendix 11, as well as her unease during one participant's interview (Section 3.5.1 and Appendix 14).

4.4.2.2 Situating the sample

The participants volunteered for the study and the sample was thus a convenience sample. The researcher had pragmatically aimed for a sample of between 6 and 12 participants. The sample seemed to represent a fair cross-section of the department (in terms of experience, number of longer-term patients seen, maximum number of sessions given, and settings worked in).

Because of the small size of the sample, men were under-represented and Counselling Psychologists over-represented, compared to the whole department. There was no a priori reason to expect differences in the responses, by gender or professional qualification.

The participants and researcher came from a department with a tradition of brief cognitive therapy. The researcher had known the participants for variable lengths of time. It is possible that the researcher is known in the department as an experienced therapist who also does other therapies. To what extent these factors influenced the participants (and if so, how) cannot be evaluated but it was hoped any effect, e.g. of a power imbalance, would be minimal. However, the experience with one participant who disclosed information after the

interview suggests that at least this participant may not have been as open as the researcher had hoped, and that maybe others also kept back relevant information.

4.4.2.3 Grounding in examples

Efforts have been made to illustrate each step of the data analysis, results and particularly the findings, with quotes from the interview transcripts so that others can follow the process and see how interpretations were arrived at. However, the word limit required by the dissertation has only allowed the inclusion of short quotations (apart from the transcript in Appendix 9). A consequence of this is that the ‘flavour’ of the interviews may be lost and there is less opportunity for the reader to make their own judgements. Few, short quotes may also give the impression that the findings are less grounded in the data than they actually are.

4.4.2.4 Iteration

This refers to the cycling between the interpretations and the interviews (Stiles, 1993). The Method (Section 2.5) and Results (Section 3.2) have described how the categories were developed by the researcher through a process of continually alternating between finding categories and checking them out with the raw data. During this process the researcher became immersed in the material, which helped to understand the participants’ views.

Iteration can also involve the participants, for example, by asking them to comment on the transcripts, so that interpretations could be revised (Stiles, 1993). In this study the participants gave feedback on a short summary of the findings (Section 3.5.2)

4.4.3 Credibility checks

Credibility checks are a way of ensuring that interpretations are internally consistent, and the research true to some underlying reality (Stiles, 1993). These checks can be used to reduce biases and increase trustworthiness but cannot completely eradicate errors. Different ways of carrying out credibility checks are mentioned in the literature (Elliott *et al.*, 1999; Mays and Pope, 1999; Smith, 1996; Stiles, 1993). It can be done by getting feedback from the participants; comparing the findings with other data sources (triangulation); putting the findings into a coherent framework; looking at whether the findings have answered the research questions; seeing whether the participants have changed as a result of the interviews; and by both researcher and participants having a reflexive attitude to the research process. Some of these are now discussed. It was not possible to use every type of credibility check in this study because of time constraints. It is hoped that the research was carried out in a systematic and thorough way so that these checks add rigour (Barbour, 2001).

4.4.3.1 Respondent credibility checks

These checks were carried out by getting feedback on the findings from the participants. Ideally, this could have involved re-interviewing them (for which the researcher did not have time), or, at least, providing them with detailed results. However, for this study, a 1½ page written summary of the findings was sent to the participants after a non-response to a lengthy account of the findings.

The findings resonated with the participants in that they thought that they accurately reflected the subject matter. The research process and findings also had an effect on the participants and they acknowledged being affected by the interview (Section 3.5.1, and

Appendix 13) and some considered changing their practice. Some participants had made changes since the interviews (Section 3.5.2 and Appendix 15).

Although the comments given by the participants may give some validity to the findings, the process engaged in by the participants was very different from the immersion in the data by the researcher. Their comments cannot be compared to the researcher's fuller understanding of the data and the findings. The lack of disagreement may make one speculate whether, in some respects, the participants were trying to please the researcher.

4.4.3.2 Readers

Although there were only six readers, their concurrence with the findings provides a source of resonance.

While the two critical psychologist readers did not carry out any coding, frequent discussion with the researcher was a very useful exercise. Agreement with the data or findings implied that they found them coherent, while disagreements helped the researcher refine categories by lumping or splitting them, or re-interpret the findings. These readers thus gave the researcher an external perspective. It also meant that the researcher had to account for each step taken in the analysis. This is in the spirit of the principles of qualitative research.

4.4.3.3 Auditor

The analysis carried out by the auditor seemed to be at a very low level of coding and thus of limited value in establishing inter-rater agreement. Since there cannot be an 'objective' version of the findings, it was not surprising that the auditor's categories differed from the

researcher's. The auditor had also probably carried out a very different exercise from the researcher's. The researcher had gone over the data many times and had an overview that was not available to another rater.

4.4.3.4 Generalisability

No attempt was made at generalisability in this study. However, it is possible that the results would be judged by members of other psychology and psychotherapy departments as being an accurate representation which would resonate with them, and so provide the starting point for research that could be tailored to a different setting.

4.4.4 Summing up of trustworthiness criteria

Credibility checks were carried out, as far as was possible within the time constraints. Care was taken to comply with procedural trustworthiness and to be transparent about all stages of the data collection and analysis. However, the limitations of these methods should be acknowledged. Barbour (2001) suggests that these methods should be treated with caution if they are used too prescriptively. Some of these methods can be seen to be more like 'technical fixes' and do not necessarily confer rigour, unless they are relevant to the design of the study or enhance the analysis.

However, it is hoped that the transparency of the process undertaken by the researcher provides sufficient credibility and shows her to be plausible and trustworthy.

4.5 Limitations of the study

Various limitations have been alluded to throughout the previous section (Methodological issues) but the main ones will be summarised here.

Although there may be a positive aspect to the loss of focus in some of the interviews (see Section 4.4.1.2), a more serious consequence is that the resulting data may have been less consistent and, therefore, would be more difficult to replicate in future studies. The tension between asking precise questions and allowing participants to interpret the area of interest in their own way is one of the dilemmas of carrying out qualitative research.

Readers of the current study might have been able to see more clearly how the various themes emerged from the data by having longer quotes from the transcripts available to them. This, therefore, limits the study in that transparency is reduced. However, the researcher was restricted by the word limit, and also followed the convention of having short quotes that is used in scientific papers.

It would have been useful to have had some measure of inter-rater agreement in this study, at different levels of coding. However, this was not carried out and was outside the scope of this study. Barbour (2002) also affirms the usefulness of having some element of multiple coding. However, she allows that, as well as actual coding by a rater, this could also include discussion of coding with other involved in the research. Future studies may wish to address this question.

Finally, in the spirit of the transparency and relativism of qualitative research, it might have been better to write in the first person. The researcher decided to be consistent with the practice in scientific papers, which is to write in the third person.

4.6 Alternative explanations for the findings

The findings are the result of the researcher's grounded theory analysis of the raw data, carried out within certain time constraints. Another researcher would construe these data differently and would collect different data from their own interviews.

A re-analysis of the raw data might have allowed more exploration of therapists' conflicts and their ways of dealing with them. For example, therapists might have specific strategies for dealing with particular conflicts that were not revealed in the current analysis.

Knowledge of therapists' decision-making in a more fine-grained way might then enable change to be tailored more precisely. For example, if therapists tend to drift with particular types of patients, e.g. patients with continual crises, they could be alerted to this phenomenon earlier in therapy so that they could become more focused.

4.7 Clinical implications of the findings

The main implications of the findings, as discussed in Section 4.3, were that therapy could stop sooner and take place in a more open culture. Such changes could be of benefit to the service and could possibly increase therapists' self-esteem. Fewer very long therapies might also reduce waiting times.

For a few of their patients, therapists may be likely to be experiencing conflicts because of the demands from patients, patients' families, colleagues, the setting in which they work, as well as intrapersonal conflicts. At the same time, the therapist is trying to do the best for their patient. This means that decisions being made may not be rational ones. The outcome may be that the therapist does not stop therapy as soon as they might. Even though the details may vary between therapists and departments, similar conflicts may be widespread.

The department and its therapists may need support to help them gain more control over the length of longer therapies – to prevent therapy 'taking on a life of its own' – by learning to make more rational decisions. It should be remembered that some patients may need a longer therapy and this can be cost-effective. For example, if the alternative to a longer therapy were hospitalisation, that would cost more. Thus, although some longer-term therapy is inevitable, the actual length is not, and it is possible that therapy might sometimes stop sooner.

The recommendations that follow are suggestions which may help therapists make better decisions about the length of therapy. However, it is important to remember that the current study has limitations which are outlined in Section 4.5. Bearing these in mind, the recommendations suggested are therefore of a tentative nature. The members of the department may be more likely to comply with the recommendations if they see their value, and if they are not too onerous to carry out. This could come about if the culture of the department changed to being more open.

4.7.1 Recommendations

1. Greater openness

- i. Being open about doing longer therapies might be facilitated by helping therapists review and stop therapy earlier, especially CMHT psychologists who have more varying demands on them than tertiary service psychologists. In the past, the department had three named psychologists to whom therapists could go, to discuss and review longer therapies and make plans about stopping (usually by session 20). Reinstating this system might help curtail drifting. This reviewing function could be incorporated into supervision or line management, or it could be separate.
- ii. Some decisions leading to therapy continuing seemed to concern patients who were not making progress or not sufficient progress, i.e. the partial reinforcement vicious circle (Figure 3-1) was operating. There might be a value in therapists noticing and acknowledging when this is happening. A more open culture might allow therapists to discuss this sooner, and so take action and set limits to the therapy. This could be discussed in the context of supervision, line management, talking to the named psychologist (Point i above) or having a caseload review with a colleague.
- iii. There might be some benefit in instituting ‘information-sharing’ sessions (e.g. a regular half-day event in the department) or journal clubs in the department. This might help psychologists become more familiar with empirical evidence (such as about therapy for specific disorders), not just using one’s experience in deciding on treatment length.

2. Training in long-term therapy

The therapists in the department are predominantly cognitive therapists who are skilled in brief therapy but may have had less training in giving longer therapies. For example, a longer therapy typically involves having a long-term plan and is not the same as the continuous series of five sessions that were described by some participants. Training might include getting as much information as possible, looking for alternative explanations and hypotheses, so that other biases are likely to be minimised. This training could be carried out in the department's skills-sharing sessions, which occur for one morning every three months. However, there is a danger that this training could seem to be encouraging therapists to offer longer therapies, and this would best be guarded against.

3. Setting realistic goals

It might be useful to set realistic goals could be set which aim for what a patient can achieve (in so far as that can be predicted), even if this is very little. It may not be realistic within the NHS for goals to aim for complete recovery: which is, perhaps, the opposite suggestion to Participant No. 10's belief – 'it doesn't seem sensible to cut out half the tumour'.

4. Monitoring patients' progress

More frequent monitoring of a patient's progress might be helpful when making decisions about continuing therapy or stopping. In the department in question, questionnaires on anxiety, depression and self-esteem, are routinely given at the beginning and end of therapy. It might be useful to give these more often. Observations may also be important (as advocated by Watts, 1980), and are something psychologists

are good at (Garb, 1994). They could be used to pick up small but significant changes that questionnaires cannot do. Estimating change might usefully be used to recognise when the patient has had ‘enough’ sessions, e.g. when the dose-effect curve, for a particular patient, is levelling off. Sharing this information with others might give therapists more confidence in their judgements, and might also be supportive. Using notes rather than relying on memory, when making a decision about the patient might also help prevent biases occurring.

5. Making ‘general rules’

In their feedback, Participant No. 9 mentioned that there was a lack of general rules in the department about extending therapy. This suggests that it might be helpful to formulate an overt departmental guideline that acknowledges that longer therapy is sometimes needed, and which also draws up practical steps to help members of the department keep the therapy ‘briefer’. The guideline might usefully contain the recommendations laid out above. With a change in the departmental culture to greater openness, the length of therapy might then be talked about, making it easier to ask for help in stopping (or continuing). Therapists’ self-esteem might also be enhanced.

6. Interacting differently with CMHT members and others

When psychologists have general guidelines to help them, and the support of their psychology colleagues, it may become easier to be firmer with others who put on pressure for therapy to continue (against the psychologist’s judgement).

7. Enhancing psychologists' self-esteem

Rather than making specific proposals here, it is hoped that the above recommendations might lead to enhanced self-esteem.

4.8 Future research

This study was exploratory and not intended to be an end in itself. The findings could be investigated further using both qualitative and quantitative methodologies.

4.8.1 Qualitative

As suggested in Section 4.5, a more detailed study, e.g. from a further round of interviews with the same or additional participants, could provide knowledge of the decisions made in relation to specific conflicts. This would facilitate better decision-making with respect to these conflicts.

The credibility of the findings of the current study could be improved by triangulation, i.e. comparing them with other data sources. Examples of this would be running focus groups with therapists who have offered longer therapies, or discussing the findings with other groups of therapists.

The study could be replicated in another psychology or psychotherapy department. This would enable the findings to be more relevant to other therapists.

A similar study could be carried out by interviewing patients who had had longer therapy, to see what they saw as contributing to their therapy being longer, and what they thought their needs were.

The findings could be taken further by asking another set of participants about the process of reviewing longer therapies and how this affects the goals of therapy.

4.8.2 Quantitative

The findings could be extended by using them as the basis for a questionnaire or survey, to find the reasons why therapists give longer therapies. The research could then be more generalisable by using more diverse samples.

Audits could be carried out on the effectiveness of the recommendations, by taking measures of the periods before and after instituting the recommendations. Measures of greater openness in the department could come from the degree to which therapists discuss longer therapies to the named psychologists, supervisor, line manager or in case load reviews; and those of making therapy brief could be measured by treatment length in the department's routine data, and methods of monitoring such as questionnaire scores and observations. This research should be done as single case designs rather than group comparison designs so that change in individual patients can be measured.

4.9 Conclusions

The study answered the research question and the findings showed that, while longer therapies were appropriately given to a few patients, therapists sometimes had difficulties in

stopping therapy as soon as they might have. Recommendations were made to help therapists shorten therapy. Extending therapy occurred in the context of the therapists experiencing conflicting demands – from the patients and from the system. Therapists tended to keep these longer therapies secret, and this may have negatively affected their self-esteem. Recommendations were made on how to make the culture of the department more open. The findings could thus have a positive effect on the department, and might also be helpful to other, similar departments.

4.9.1 The experience of doing qualitative research

Being rather a novice, I was learning as I went along, and not surprisingly, discovered that the reality is different from reading about it, and that the whole process was even more time-consuming than I expected. It was interesting becoming immersed in the data, yet standing back and not letting my preconceptions colour the findings (a similar process to what one does in therapy). I was impressed, moved and humbled by the hard, dedicated work done by the participants, often seemingly against the odds. I found things I wasn't expecting and, as a result, have resolved to modify my therapeutic practice. But I regret writing in the third person. That was a distancing experience, and seemed to go against the ethos of this kind of research.

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6 Appendices

6.1 Appendix 1 Semi-structured interview schedule¹

Participant № _____ Years qualified: 0-5 _____ 5-10 _____ 10+ _____

Approx. no. patients seen per week _____

Ever seen patients for 26 sessions or more? Y/N

 If Yes – in last 5 years? Y/N If Yes – approx. how many patients? _____

 If Yes – what was the highest session number you offered? _____

Introduction

I'd like to ask you about why you have offered a patient(s) 26 or more sessions of therapy. It may help you to think about a specific patient(s), although it is your decisions I am interested in.

Additional prompt questions

At what point in therapy did you decide to offer 26 or more sessions?

- Before you started?
- At the beginning?
- During the course of therapy?

How did you decide on the final number of sessions?

What were your goals in therapy?

What was your reason(s) for offering (more) sessions?

- Were they to do with the *patient*?
- Were they to do with *you*?
- Were they to do with the *relationship* between you and the patient?
- Any other reason?

Has supervision or line management played any part in deciding on the number of sessions you offered?

- In keeping you going?
- In keeping you focussed?
- In helping you to stop?

Closure

Is there anything else you want to tell me, or ask me, before we finish?

How have you felt telling me these things?

Is there anything you would view differently now? Thank you for your time.

¹ In practice, the topics were not always covered in the order given on this schedule.

6.2 Appendix 2 Ethical approval

Our Ref: LB/A01.027

Ms Christine Kuchemann
Psychology Department
The Warneford
Headington
Oxford

Applied & Qualitative Research Ethics Committee
Research & Development Department
Room 13, Manor House
The John Radcliffe
Headley Way, Headington
Oxford OX3 9DU

Tel: 01865 222758

Fax: 01865 222699

E-mail: lorraine.busby@orh.nhs.uk

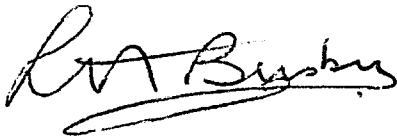
Dear Ms Kuchemann

6th August 2001

RE: A01.027 - An exploratory study of factors which influence therapists into offering 26 or more sessions of therapy

We have received a letter dated 11th May 2001, from the Oxfordshire Mental Healthcare NHS Trust, who are providing indemnity for the above study. I can now confirm final approval and wish you every success with your study

Yours sincerely



Mrs Lorraine Busby
AQREC Administrator
Applied & Qualitative Research Ethics Committee

6.3 Appendix 3 Managerial approval

Tel: 01865 223238
Fax: 01865 223033

Adult Services Department
Littlemore Mental Health Centre
Sandford Road
Littlemore
Oxon

Christine Kuchemann
Principal Clinical Psychologist
Warneford Hospital
Warneford Lane
Headington
Oxon

21 August 2001


Dear Christine

CLINICAL DIRECTORS APPROVAL FOR DISSERTATION

Thank you very much for your letter of 20 August. I was very interested in the study and am sure that the results will be of great relevance to the Trust. I remember David Westbrook presenting some results on outcome study at a Tuesday morning Professorial Unit Meeting around seven years ago which, I think, showed that people with personality difficulties did not benefit very much from standard CBT within the department. I may have remembered this incorrectly however. I mention this because I guess that it is this type of person who generally is given more than 26 sessions of treatment. As he is your supervisor, I am sure that you have already been through his work with him.

I hope the study goes well and I would be very interested to know the results in due course with best wishes.

Yours sincerely


Simon Hampson
Clinical Director
Adult Services

6.4 Appendix 4 Confirmation of indemnity insurance

Julie Waldron
Chief Executive
Warneford Hospital
Warneford Lane
Headington
Oxford OX3 7JX

01865-223966

Ref: JW/jrn

11th May 2001

Dr Christine Kuchemann
Principal Clinical Psychologist
Psychology Department
Warneford Hospital

Dear Dr Kuchemann

I am writing to confirm that Oxfordshire Mental Healthcare NHS Trust will indemnify you, for your Research project A01.54 'An exploratory study of factors which influence therapists into offering 26 or more sessions of therapy' as described in your application to Applied Quantitative Research Ethics Committee (AQREC). This commitment is dependent on the formal approval of the Applied Quantitative Research Ethics Committee and on the understanding that you have contract of employment with this Trust.

Yours sincerely



Julie Waldron
Chief Executive

6.5 Appendix 5 Preliminary announcement

Psychology Department
Warneford Hospital
Headington
Oxford OX3 7JX

My research dissertation for the Clinical Doctorate (Admission with Academic Credit) will be:

‘An exploratory study of factors which influence therapists into offering 26 or more sessions of therapy.’

For this study, which has been approved by the Applied and Qualitative Research Ethics Committee, I am looking for participants from psychologists in this department who have seen at least one patient for 26 or more sessions. I would like to know who would be willing to be interviewed and audiotaped by me for about an hour on their reasons for giving this many sessions to one or more patients. The enclosed Participant Information Sheet will give you more information. You are welcome to talk to me if you would like to know more.

When I have had the names of volunteers I will randomly select a sample of about six whom I will approach and talk to about the study. All interviews will be anonymous and what is said will be confidential.

Please let me know, in the next two weeks, whether you would be willing to take part. You may contact me by writing to me at the above address or phoning me on (2)26436 or the secretary on (2)23968.

The study has been reviewed and approved by the Applied and Qualitative Research Committee (AQREC No. A01.027).

Christine Küchemann

6.6 Appendix 6 Participant information leaflet

Version 4 (July 2001)

Psychology Department
Warneford Hospital
Headington
Oxford OX3 7JX

Tel. (01865) 226430

Study title: ‘An exploratory study of factors which influence therapists into offering 26 sessions or more of therapy’.

AQREC No: A01.027

Name of researcher: Christine Küchemann

Invitation

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read carefully the following information and discuss it with others if you wish. Please contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Consumers for Ethics in Research (CERES) publish a leaflet entitled *Medical Research and You*. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London N16 0BW.

What is the purpose of this study?

Research has suggested that, while therapy duration is related to outcome, with increasing duration returns may diminish. Therapists sometimes see patients for lengthy periods of time, which may not always be the most efficient use of resources.

I want to find out more about the reasons why psychologists in our department sometimes offer patients 26 or more sessions of therapy. The study forms part of the department’s concern to find ways of improving our service. Although we know that most of us have given some patients a longer therapy we do not know the various reasons people have for doing this.

The interviews will take place over the next few months.

Why have I been chosen?

I have selected you from those psychologists who indicated they were willing to take part.

What would happen to me if I took part?

I would interview you for about an hour and ask you about your decisions to give some patients 26 or more sessions. With your permission, I would like to tape-record the interview.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you would have this information sheet to keep and you would be asked to sign a consent form, a copy of which you would be given. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What are the possible advantages and disadvantages of taking part?

You may appreciate the opportunity to reflect upon your clinical practice. The findings may help us to work better with patients in the future. However, you would have to give up about an hour of your time.

Would my taking part in this study be kept confidential?

Information which is collected about you during the course of the research would be kept strictly confidential and secure. Your name would not be attached to any information. The only other information I am collecting is broad bands of years since qualifying (in such a way that you would not be the only one falling into a band, and thus would not be identifiable).

What will happen to the results of the research study?

A report of this study will be submitted as a dissertation for the Oxford/Open University Doctorate in Clinical Psychology (Admission with Academic Credit). You would not be identified in the report or in any publications of the study. However, with your permission, any words you may say during the interview may be used, anonymously, in the presentation of the research (with any identifying information removed). The study is funded by the Berkshire and Oxfordshire NMET Consortia.

Who has reviewed the study?

The study has been reviewed and approved by the local Applied and Qualitative Research Ethics Committee.

What happens next?

If you are willing to take part, I will contact you in about one week to answer any questions you may have and to arrange a time for you to take part.

Thanks for reading this. Your help with this project would be greatly appreciated.

Christine Küchemann

6.7 Appendix 7 Participant consent form

Version 2 (June 2001)

Psychology Department
Warneford Hospital
Headington
Oxford OX3 7JX

Tel. (01865) 226430

Participant Consent Form

Study title: ‘An exploratory study of factors which influence therapists into offering 26 sessions or more of therapy.’

AQREC No: A01.027
Name of Researcher: Christine Küchemann

Please initial boxes

- 1. I confirm that I have read and understood the information sheet dated July 2001 for the above study, have had the opportunity to ask questions, and have received enough information about the study, and satisfactory answers to all my questions. ☐
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
- 3. I agree to the interview being audiotaped. ☐
- 4. I agree that any words I may say during the interview may be used, anonymously, in the presentation of the research. ☐
- 5. I agree to take part in the above study. ☐

_____ Name of Participant	_____ Date	_____ Signature
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_____ Name of Researcher	_____ Date	_____ Signature
-----------------------------	---------------	--------------------

6.8 Appendix 8 Transcriber's confidentiality form

Version 1 (June 2001)

Psychology Department
Warneford Hospital
Headington
Oxford OX3 7JX

Transcriber Confidentiality & Security Agreement

Study Title: 'An exploratory study of factors which influence therapists into offering 26 or more sessions of therapy.'

AQREC No. A01.027

Name of Researcher: Christine Küchemann

Please initial boxes

1. I agree to keep the interview audiotapes and transcripts confidential

SKA

2. I agree to keep the audiotapes and transcripts secure (e.g. hard copies to be kept in locked storage cabinets and soft copies to be password protected)

SKA

Name of Transcriber (Block Capitals) SUSAN HUTTON

Date 13.10.2001 Signature SKA

Address 59 CYRIL STREET WEST, TAUNTON, TA2 6JD

Name of Researcher (Block Capitals) CHRISTINE KÜCHEMANN

Date 15-10-01 Signature C. Küchemann

6.9 Appendix 9 Transcript of Participant No. 6's interview

So I'd like to ask you why you've offered one or more patients twenty-six or more sessions of therapy, and, it may help you to think about specific people, but it's your decisions that I'm interested in.

5

Three of the people, the people who seem to have really engaged in cognitive therapy and be using it themselves, and seem to grasp the model, show some signs of progress, but then have setbacks during therapy really, a feeling that they're not at a stage where it would be appropriate to discharge them. I think with those people I have also...they have been people with low self-esteem, as well as the presenting problems and these have tended to [inaudible], things have tended to shift, anxiety, depression.

10

Shifting problems.

15 Shifting problems through treatment. And these people are having to work, done more work on assumptions and beliefs as well as the Axis I issues, if you like.

So at what stage did you decide to carry on?

20 I think...I think with all the people I had sort of, ten sessions in mind to start with, but then when the ten session sort of limit came up they were still with the shifting problems, and there still seemed quite a lot to work with, more you could do I really felt they could benefit, and I was hoping that they'd get better.

25 *So it wasn't about maintaining them, it was about continuing progress.*

Yes, continuing treatment really, yes, definitely. I think if they had been feeling better then I would have found it easier to discharge them into follow up, but they still had ongoing problems that they were struggling with that made it hard to finish sessions. I think with all those people I did sort of take it five sessions at a time, but just kept going. (laughs).

30

So at each of those points, five-session points, were you doing a review in your head, or a review with the patient, or with your supervisor, or...?

35 A review with the patient, and when I was discussing people in supervision, and the supervisor was aware of how long it was going on, and was the line manager. I don't know if I was actually spelling out...

The supervisor was your line manager?

40

Yes.

You don't know whether you were spelling it out?

45 Exactly how many sessions. (laughs) But the fact that, you know, they did, there was somebody else discussing it, these things, and had a rough idea, of sessions.

So that sounds a bit as though you were embarrassed about the number of sessions, not wanting to be quite open about it.

50

I think when I go over twenty I start thinking, is this OK? What would other people think? I think there's a mixture of feelings. I think my line manager thought there were exceptions where it was OK. I felt reasonably OK. I think it's more difficult to admit to.

55 *So do you think that's partly a function of being relatively newly qualified?*

That I worried about it?

Yes, that you were worrying in this way, what do other people think and...

60

I think it's more this expectation that we can only offer very short-term treatment given the waiting list we have, and, [pause], breaking the rules in some way. I think it's like I'm still struggling with those issues really. When you see somebody for thirty sessions, it does have a look of... It's quite difficult.

65

And so when did you...how did you come to decide you were doing five sessions and review, that you were going to finish?

[pause] Mm, that's interesting. I think when the people concerned were moving towards
70 recovery, and their scores on questionnaires were lower, so, sort of mildly depressed or
mildly anxious rather than moderately, and questionnaire scores were, or the Beck scales
were sort of approaching ten. And I think also, which, it was when they, they were also
feeling more able to cope without the sessions, and... Because I think seeing people for that
many sessions gives a danger of dependency. And think, I think with probably all these
75 people, they feel quite anxious about ending the sessions and sort of working on things
independently; I think it was at the stage where they were feeling a bit better and feeling
ready to do that, I then found it easier to say then, this is the right time to go into follow-up.

So you're the one that made the decision.

80 Well, I think it sort of, you know, it was discussed, and I think it was at the stage where
they, you know, were feeling a bit more comfortable with the idea. I'd been preparing them
for the end of the sessions, but... And I probably was responding to their anxiety between
the sessions. But also taking account of the symptoms the symptoms they had presented
85 with, how distressed they were [inaudible].

Any pressures on you to continue or to stop?

[pause] Not... Not really. I mean I guess just know that I didn't want it to, to keep going
90 on and on, pressures of having a waiting list really, but...

*Because some of the people have mentioned pressures coming from the team, or from the
GP. Sometimes to go on seeing somebody.*

95 Mm.

As well as to stop, of course, like line managers.

With all of these people actually getting clear messages from the team and GPs.

100

So what sort of problems do the patients have?

Shall I go through them all? (laughs)

105 *Yes, yes.*

One person presented initially with panic and social anxiety, but he also had very low self-esteem, and once we'd made some progress with the social anxiety he became very severely depressed. Another was, she presented initially with severe depression, but was also quite
110 socially anxious. Another person was quite severely agoraphobic and depressed. And there were, there were, there were some self-esteem issues, but there were quite specific ones rather than general problems in certain areas, and sort of working with one belief. The other person, somebody with...

115 *The fourth one?*

The fourth one. Somebody with longstanding vomit phobia, which had led to, well actually she had anorexia as well, a continuation of problems and low mood and self-esteem.

120 *Would you describe them as having personality disorders?*

[long pause] It's really difficult. I don't think they'd meet diagnostic criteria for personality disorders D.S.M. IV. I think they all had longstanding self-esteem issues, and had problems like, ever since childhood they'd had problems with anxiety or depression.
125 But I don't think they necessarily fit in to those categories. And I think, I mean, only one of the people has a significant inter-personal problems. The other people were fairly good at making relationships and things like that actually, which probably meant they were then more able to make use of therapy, I guess.

130 *Have you worked with personality disordered people?*

Yes. (laughs)

And, have you done longer therapies with them? Are they the twenty session type people,
135 *not as much as twenty-six?*

I guess the people who come to mind are people who've had really very significant interpersonal difficulties, and very severe problems who haven't been able to sort of engage in and make use of therapy. The one that immediately comes to mind.... And there was
140 somebody I saw recently who had personality issues who made very good use of ten sessions, and use of self-help material and I had wondered at the start, you know, is this somebody who's going to use a lot of input to get to things, and she made very good use of it, and I hadn't thought she would. So I think it's really difficult to predict how it's going to go.

145 *Yes. You haven't said much about the fourth person.*

Have I not?

150 *No.*

No, I guess she's a little bit different to the others. She didn't actually engage fully in sort of cognitive therapy and there were social issues, that seemed to be more important, that seemed to be undermining what she was trying to do. I think I stayed involved with her for
155 more than twenty-six sessions, because, she was making some progress. I'm not really sure what that was down to, whether it was the support and encouragement of actually engaging in cognitive therapy. And I think because she was very low weight it was very difficult to pull out, because of the risks of deteriorating, and she was very anxious about that as well, so that's why we sort of continued, and she's made steady progress.

160 *And so she was anorexic, was she?*

Yes. Yes. anorexic and vomit phobic.

165 *So with her it was slightly different, in that you were...you were worried about her, you felt that you had to stay in touch with her and keep going with her, and that element of it might...?*

170 Yes, it was a bit different in some ways, it was...yes, I was worried about her being, about
her low weight. I guess a similarity would be between the four of them would be the
client's anxiety about ending therapy, I guess. And she was really anxious about losing
weight.

175 *So how did you come to finish with her?*

Well it got easier as she put on weight. And then, we had, we had regular reviews, and at
the last review we considered the options, which were, either her taking bigger steps really
and do more challenging, with behavioural experiments, or her being supported by a
practice nurse, for sort of ongoing support, not from me. And she decided that she wanted
180 ongoing support rather than to work more in a cognitive therapy-type way. That was easy,
because she was very different from the beginning. So she decided, chose that.

185 *Well, she decided, and you decided as well, but with the others ones it was a bit more you,
than them... Or was it the relationship between you? Do you think there's something about
people that hooks you in, or...?*

Yes, I think...

190 *Or even makes you collude with them...*

I don't know, because, I think this is saying something about finding it difficult to discharge
people who are anxious about being discharged, but on the other hand, you know, they did
have...I discharged them at a point where they had sort of improved quite a bit. In other
ways it might seem appropriate to because they are feeling less distressed and have reached
195 a stage where from moderately depressed or moderately anxious, things were going well.
So, it could go either way, I think. (laughs)

200 *Well I suppose sometimes it might be easier to keep going with somebody because you like
them, or keep going because you dislike them slightly but feel guilty or feel you ought to,
or...*

Mm.

...something like that.

205

Yes, I can, I can see that. And I guess if somebody does engage well with cognitive therapy, it's easy to run with them. So you might say to yourself, well they're more likely to get something out of it, because they're engaged but I guess also it would be more of a pleasure to work with them and be their therapist and to continue.

210

Yes, I think I do prefer those sorts of people really. (both laugh)

I feel a bit, it's a bit difficult to admit that I continue longer with people just because I like them, but I'm sure there must be something in that, if I'm honest.

215

So what part do you think might have been played by supervision or line management in deciding to carry on or to stop or whatever?

Well, not being challenged about it. (laughs)

220

So a sort of, negative way?

Yes. In the absence of somebody saying, you know, what about discharging this person, I think I'm more likely to carry on. And I guess, my supervisor, or particular supervisors would be more likely to say that person's hasn't changed, and that person's not engaging and....

225

To say to stop?

230 Yes. They don't seem to be getting anywhere, and asking why continue?

Did the supervisor say that about some people?

Not about three of them, but, the fourth person with vomit phobia and anorexia, I think in supervision we discussed does it need to be me supporting this person or can it be someone else and that influenced the discharge in the end. And also thinking about setting more

235

challenging behavioural experiments and things like that, sort of contributed to that decision-making process as well.

240 *It sounds very much as though you keep quite focused because you are reviewing quite frequently, and then you don't drift along into a longer therapy.*

No. I think that helps. But I guess it can still be a bit of denial about ending and things. Some people when you have a review, it really does feel like you are deciding whether to
245 continue or not, with other people, I think there's a sort of assumption, you're going to continue but let's just check it out and think about it.

What's the difference then, between those types of people?

250 I think it would be really whether...whether they seem to be engaged in therapy and it makes sense to them. It might depend slightly on levels of distress, if they're very distressed, it might be difficult to contract an ending. But I have recently decided to end with somebody who is very, very distressed, her model was completely different, so we decided that there was not point in continuing at this stage. But that is quite difficult, because she was very
255 severely depressed. It was only after about six or seven sessions.

And maybe it's, maybe it's because they're not so much personality disorder patients, because I know that there are patients where I have no focus really, and I just drift on and on and on. Or they bring new things, and you can never, can't actually finish, kind of thing.

260 That can be difficult too... Yes, I mean, the people I've talked about haven't really been like that.

No, no.

265 I think they, those sorts of people are difficult to work with, and I probably would run on for a few more sessions because of that but I probably wouldn't actually gone on to twenty-six sessions.

270 *[inaudible].*

[inaudible] for five or something.

275 *Yes. And where I've waited for sixty sessions or ninety sessions, I still feel we haven't started yet. (both laugh)*

Mm.

280 *But their problems are so awful that you can't stop seeing them, or there's something that keeps you going. But it sounds as though your patients weren't like that.*

[pause] Yes, I guess I might not come across people like that so much, but...

285 *Do you think your case load has changed over the years?*

Yes, I'm seeing more complex people. [pause]

290 *Anything else you want to add? [pause] Because it seems as though we have covered everything more or less.*

Mm. I think so, [inaudible].

So, how's it been, talking to me?

295 Fine, yes.

OK.

300 I hadn't really sort of thought about it much before, so, I'm sort of thinking on my feet.

That's OK. Is there anything you would view differently now?

[pause] I'm not sure, but I think I'll think about the issue of whether I'm responding to the client's anxiety about ending, or whether it is reasonable though distressing. I think I might
305 think about that a bit more when I'm coming to the end of therapy with people.

OK, thank you.

6.10 Appendix 10 List of categories, for each interview, from open coding

Participant No. 3
Type of patient Pressures from the team to take the patient on Reasons for taking on (and offering treatment) Why carry on Why can't stop Trust (need sessions to gain the patient's trust) Support from line manager My feelings (towards the patients) What I get out of it My resistance to long-term work The place of supervision
Participant No. 4
Type of patient At the outset (goals and expectations) Why they are longer therapies Carry on Stopping Drifting (carrying on for the wrong reasons) Positives about going further Negatives – from patients (or the relationship, or feelings) Relationship/feelings Reviews Different types of interventions Supervision
Participant No. 5
Type of patient Reasons for taking on Feel at beginning it will be long-term Difficulty in deciding how patient will respond Different forms of therapy (e.g. bouts) No hard and fast rules – sessions no. varies from patient to patient No hard and fast rules – depends on how I'm feeling Therapist's goals/aims Goal may not be to go all the way Patient's goals Patient responds well Hang in there Reasons for continuing Reviews Stop when getting nowhere Justification of long-term therapy Others' influence into shorter therapy

<p>Others' influence into keeping going</p> <p>Supervision/discussion with others</p> <p>When patients don't change</p> <p>Dilemmas – support/therapy; risking discharge/risking dependency</p> <p>Reasons for stopping</p> <p>Pressure from others</p> <p>Therapeutic relationship</p> <p>How I've changed</p>
Participant No. 6
<p>Discussion in supervision/line management</p> <p>Review – how to decide</p> <p>Mixed feelings (re continuing or ending). Indecision</p> <p>Carry on</p> <p>Hard to finish</p> <p>Reasons for stopping</p> <p>Type of patient</p>
Participant No. 7
<p>Trust</p> <p>Feelings towards the patient</p> <p>Ending properly (by extending)</p> <p>Aims of therapy</p> <p>Reasons for stopping</p> <p>Reasons for extending</p> <p>The decisions to offer more</p> <p>Pressure from others</p> <p>Supervision</p> <p>Case management and scrutiny from others</p> <p>The importance of contracting</p> <p>The type of patient (who gets more)</p> <p>Maintenance</p>
Participant No. 8
<p>Take load off someone else</p> <p>Pressure on therapist to succeed/make it all right</p> <p>Type of patient</p> <p>Aims of therapy</p> <p>Patient's response to therapy</p> <p>Expectations of patient/therapy</p> <p>Patient not as expected</p> <p>Expectations/views of self</p> <p>Why extend</p> <p>Extend for wrong reasons/can't stop (but should)</p> <p>Mixed feelings re carrying on/difficulties</p> <p>Reasons for stopping</p> <p>Focused or undisciplined</p> <p>Therapy has to be justified. Sessions have to be worth it/get results</p> <p>Inexperience lengthens therapy</p> <p>Something between patient and therapist</p> <p>Consequences of supervisor's trust</p> <p>Guilty secret</p> <p>Reviews</p>

Participant No. 9
<p>Pressures from outside</p> <p>Need support from a team</p> <p>Guilt</p> <p>Feelings re interview</p> <p>Contracts</p> <p>Goals at outset: work during therapy: outcome</p> <p>Patients' problems</p> <p>Patient characteristics: positive</p> <p>Patient's difficulty in using therapy: negative factors</p> <p>Patient's use of therapy: positive factors</p> <p>Patient's previous experience of therapy</p> <p>Therapist's feelings towards patient</p> <p>Therapist factors</p> <p>Therapeutic relationship</p> <p>Supervision</p> <p>Long-term was long ago</p> <p>Decide to stop – maternity leave</p> <p>Want to stop</p> <p>Was recently qualified/Not aware of reality</p> <p>Process – ongoing experience</p> <p>Offering treatment versus other factors</p> <p>Awakening to reality/Disillusion/Held back? Can't develop own potential</p> <p>Learning – for the future</p> <p>What a psychologist can/can't offer</p>
Participant No. 10
<p>Work on my own – with a waiting list, therefore reluctant to take them on (struggle)</p> <p>No one else to see them in this set-up</p> <p>Know before I see them</p> <p>The changing types of referrals – chronic, long-term, etc</p> <p>If patients don't attend – can't become long-term therapy (chance element)</p> <p>Own responsibility to be available</p> <p>Carrying a burden for other professionals</p> <p>Reasons for continuing/offering more</p> <p>Unpredictable course of therapy</p> <p>Review</p> <p>Goals</p> <p>Sometimes have to stop/give up</p> <p>Monitoring/discussion with colleagues (no secrets)</p> <p>Feelings towards patients</p> <p>The relationship</p> <p>Factors leading to continuing</p> <p>Fit in with the system</p> <p>Own change</p>
Participant No. 11
<p>Type of patient</p> <p>What long-term means & how therapist fits into that</p> <p>Reasons for the special, idiosyncratic service she offers, which the</p>

patients deserve
Supervision, sharing the burden, and being open
Feelings towards the patient
What therapist gets out of it
Importance of the relationship with the patient
My special skills
The type of therapy
Therapy in relation to other services
Negative feelings towards patients
Reasons for stopping
Limitations to what I offer
Self-doubts re the therapy therapist offers
Lack of guilt/secrets
Failure/when it doesn't work out/mistakes
Other professionals misunderstand the purpose of therapy
Importance of reviews
Reasons for going on/extending
Left-overs

6.11 Appendix 11 Examples of memos

Participant No. 6 seems very cognitively focussed but the patient seems a slippery customer, e.g. by being up and down, and with shifting problems. Although they review every five sessions, they just keep going. Is it a focussed drifting? Is it putting the patient's need before other considerations? Similarly, they review and discuss it with their supervisor, but they aren't completely upfront about the number of sessions. Is this because they are embarrassed; or feel they are breaking rules? They seem to comply with the understanding about trying to keep to ten sessions but they don't. Yet, they seem to have felt better when someone else knew about these longer therapies – as though transferring responsibility. A conclusion might be that the 'secret' is better for being shared, so as to share the responsibility. If someone else knows and doesn't say stop, then maybe it's not so bad to carry on.

Participant No. 6 The impression I have is of people really putting themselves out for their patients. There may be a satisfaction for oneself from that, but the patient's well-being definitely comes first. Therapists are doing something against the odds. That, despite the pressures, therapists try to do a good job, not just a pragmatic job. And that they are really helping people when they do this (on the whole). This should be valued – people shouldn't have to feel bad about this (and keep it a secret), as some seem to do.

Although **Participant No. 3** gives the impression of knowing exactly what they're doing e.g. making predictions and giving %, (and compared to many other psychologists) they actually bumble and stumble into situations that go against prediction or drift on, turn out to be more serious than expected, or can't risk stopping because of fears of admission or suicide attempts.

Participant No. 3 There's also the influence of the team upon them either in making joint decisions or in appeasing the team and thus taking a monitoring role. To keep the team happy they will do work that they really have little or no time for, e.g. monitoring a patient for a very long time (years). Conflicts with the team.

Participant No. 3 The tension/dilemma between feeling responsible, making amends and it being burdensome. Defending themselves against burdens.

Participant No. 3 The impression of the great burden that these long-term patients place upon them and the sense of responsibility, especially on a bad day, and how they must be trying to defend themselves against being aware of this (on good days). The impression that it could become too much to bear.

Participant No. 3 A sense I get, that as they're talking they're getting more and more tangled up, overwhelmed saddened and demonstrating the burden – as if to justify what they do, that it's OK really, or is it? That this work is so difficult that it would be impossible if they did not really empathise with the patient (and making it up to them). It is difficult to bear, and to listen to, they're being heroic – and is immensely sad and burdensome to listen to. This will be specific to them, or at least, extreme, this compulsion for atonement. But do we all have it a bit? Is it being too omnipotent, in the sense of expecting too much of ourselves?

Participant No. 9 I remember their extreme discomfort at being taped. At the end, after the tape recorder was switched off, they revealed some of their 'real' feelings about a patient as though this was really terrible, whereas I don't think this is that uncommon. I remember how cheated I felt that the interesting stuff was coming out after the interview, and that I wouldn't be able to use it, unless I could find shreds of evidence about it on the tape. I also remember their discomfort, and how uncomfortable that made me feel. As though I was putting them through something awful – because I was taping it – as though I was checking up on them, that they didn't want this to be known (to whom?). How can I not lose this?

Participant No. 10 You quickly become aware of the great burden this person takes on, yet they are making light of it. Denies it's a burden and you wonder how that can be – if you really engage with difficult patients they're a burden. NB They also mentions that they're off to play a sport – so they do have a release mechanism, something to ease the burden.

6.12 Appendix 12 Participants' feelings after the interview

Participant No. 3 Lines 336–338
I've felt like one of my patients might have. Well, fine, I have felt fine about it. But what it does make me wonder is whether I need to spend a bit more time in thinking about how I select people I may take on for long-term treatment.
Participant No. 4 Line 489
Fine. I think it's nice to, to think about some of these people.
Participant No. 5
Not asked.
Participant No. 6 Line 299
Fine, yes.
Participant No. 7
Not asked
Participant No. 8
Not asked
Participant No. 9 Lines 536–539
[pause] I think it's... The questions that you've asked have been more difficult for me to think about, because it seems like a long time ago, even though it's probably only, well it was about two years ago I stopped seeing these people, so it's difficult to be clear. Although throughout the course I've remembered more and more details that have helped me to sort of, clarify my answers. I think if we were to do the interview again, and record it again, I could probably be clearer and more concise, but I've just kind of rambled on, sort of helped my thought processes that way. I feel certain that I will be identified.
Participant No. 10 Lines 491–493
Well, I mean obviously it's...it's very helpful to be forced to reflect upon what you're doing. I think it's very... I think one feels that one is protecting one's position rather than looking for faults in it, and justifying it. But other than that...
Participant No. 11 Lines 626–627
Mm, interesting. Concerned at times that I'm not giving you what you want, but... And I've been talking about things that are of interest to me.

6.13 Appendix 13 Effect of the interview on the participants

Is there anything you'd see differently now?

No. 3 It's made me think whether I need to spend a bit more time in thinking about how I select people I may take on for long-term treatment. ... I think one's feelings do come into it. ... I need to very carefully monitor, not necessarily the times when I may offer a lot of effort really, but the times when I don't, by which I mean the people with whom I may not click in quite the same way, who may still have vast needs. ... to be a bit more overt in what makes me make those decisions.

No. 4 What's occurring to me from talking to you is about, there is something about supervision, and it's tied to the service thing I think, and that when you're kind of lower down in a sense, more newly qualified ... I have supervision about the quality of the work but not really those nitty-gritty things about the, what the service can cope with. [*'case management supervision'*] ... sometimes it seemed quite legitimate to see people for a longer period of time, but actually I think that quite often you do just drift ... and you need those conversations, that kind of management checking in, maybe in a supervision-type way.

No. 5 Since the original interview we have got into practice the meeting to review the thing ... it makes you stay aware all the time ... You become more focussed on, what can I do or can't do.

No. 6 I'll think about the issue of whether I'm responding to the client's anxiety about ending, or whether it is reasonable though distressing. I think I might think about that a bit more when I'm coming to the end of therapy with people.

No. 7 I have to re-emphasise the importance of contracting. The person I'm seeing for the longest term, I have the loosest contract with. Then you drift.

No. 8 The third one – the guilty secret one – I would see it much more of a mistake, but I did even before we talked about it. And I feel more positive about the other two actually.

No. 9 I've already said that I'm, as part of a learning process, I'm now much clearer about setting sessions limits, contracting in, checking out that people can use therapy. I guess before, I wasn't so clear about that when I first started working, I wasn't so clear about that.

No. 10 I might count the number of sessions. ... I think I've got a rough ... I know. I know when I'm seeing someone for the 12th time or the 6th time. ... but I haven't been writing down an actual number for patients for a long time. And I'm trying very hard to be a good person and get it started again.

No. 11 I'll go away thinking about guilt, because that's the question I couldn't answer. Something I'm blind to there.

6.14 Appendix 14 Researcher's memo to post-interview information

I remember their extreme discomfort at being taped. At the end, after the tape recorder was switched off, they revealed some of their 'real' thoughts/feelings about one/more? patients (can't remember) as though this was really terrible, whereas they were not uncommon (according to my, and others' reported occasional experiences/feelings towards patients). I remember how cheated I felt that the interesting stuff was coming out after the interview, and that I wouldn't be able to use it, unless I could find shreds of evidence on the tape. I also remember their discomfort, and how uncomfortable that made me feel. As though I was putting them through something awful – because I was taping it – as though I was checking up on them, that they didn't want this to be known (to whom?). How can I not lose this?

6.15 Appendix 15 Participants' feedback

No. 3
This looks absolutely fine.
No. 4
This seems a fair summary. I don't think that I personally raised issues in all the categories but they seem reasonable. I can't see that you've left anything out.
No. 5
'Taking the patient on'. ✓✓
'Starting therapy'. Work on assumption that short is good – and should assume from beginning that things can be sorted – or there is no purpose at all during first sessions.
'Stopping therapy – external factors make it easier to stop'. So what is the significance of this – psychologists just can't make decisions I wonder?
Second section – 'that therapy should be brief' – if possible – but a recognition that some individuals will require longer. I guess it is about recognising one's limitations.
'Trying to be a good psychologist – change'. Yes, maintenance does not seem to be an option.
'Burdened'. Can also be set up to be the one who can always cope with long-term patients, therefore be unfairly burdened.
No. 6
I think this summary of the results sums up the key areas for me.
No. 7
'Offering more'. This is where drift occurs.
Other difficulties in CMHTs include keeping people on because others are burdened, or you feel (arrogantly) that there's no one else to see them.
Also working to time limits often not supported by team colleagues – being 'precious' etc.
No. 8
I think it looks good – excellent. Categories do seem to describe what we discussed. They make sense. I don't think you've left anything important out and I think I have said most of what I wanted to say. However, a few months down the line – and with more experience, I think I would think differently about things now and do things slightly differently.
As I have gained more experience, particularly with complex cases, I tend to be better at dealing with things like: crises at every session. I am also perhaps less likely to think – if I could just have longer with her/him, things would be better – I think in a way this is related to an increase in confidence. Maybe I thought before – it is my inexperience that is slowing progress – perhaps if I had more sessions, worked harder I could make up for my inexperience. This is very much off the top of my head but these are some of the things that I think have changed.
Also, but maybe it's negative, I have perhaps become a bit 'harder' – tending perhaps to think more quickly – if there is very little sign of progress perhaps we should stop – maybe this is good but maybe it isn't.
I think basically an increase in my own confidence has led me to be less likely to 'waste' a lot of time.

However, I still think that some patients would benefit from more sessions – largely because their story may be so long and so important to formulation etc. AND because of building up a trusting therapeutic relationship.

No. 9

‘Taking the patient on’. There are some general rules, but not when it comes to extending. It’s not always clear, no consensus amongst dept.

‘Starting therapy’ ✓

‘Offering more’ ✓

‘Stopping therapy’ ✓

‘Trying to be a psychologist’ ✓

‘Burdened’ ✓

‘Psychologists’ sense of responsibility’. When patients have had previous difficult therapy or a raw deal in life.

‘Psychologist denigrated by others’. This is not my experience.

‘Painful awakening – shame and guilt’. Not my experience, more like sad, despondent, impatient.

No. 10

‘Taking the patient on – no hard and fast rules’ but flexible criteria.

‘Offering more sessions’ – seek advice more often from a colleague.

‘Stopping therapy’ – seek advice from a colleague.

‘Managing conflict’ – recognition that therapy should be briefer rather than brief.

‘Painful awakening’ – do *not* feel shame or guilt.’

No. 11

Maybe the positive aspects need more emphasis.

My comments do seem a bit at variance with what you have put forward – but maybe I’m an ‘outlier’ in your sample.

Important area for me is one involving shared learning with my complex, long-term cases, in which we both can benefit – I understand more and learn and think about how to ‘do it better’ and (hopefully) they ‘improve’ at least to some extent. Also it’s constantly interesting – never dull – always new and therefore a challenge that I *like* (not a conflict).

NB Don’t remember at all what I said before, so can’t be at all sure my reactions here are consistent with the information you already have.

‘Offering more – not making progress’. This is surely another question: if no progress – I go on if I have a sense that I could/they could; if there is progress then I want to judge whether it is stable/maintainable; has made a ‘significant’ difference, and will continue with that continued therapy.

Stopping therapy’. This sounds as if one never reached an agreed, satisfactory, stopping point. I don’t much experience the conflict here.

‘Painful awakening – shame and guilt’. No I don’t (may be I should!!). Personally I feel that I have improved/developed as a therapist over the years and therefore feel better now than previously about what I can offer my patients (though fully aware still that I can and do make mistakes).

As far as I am concerned (and I may be atypical) the emphasis on conflicts is too great and self-esteem doesn’t come into it.

Oxford Doctoral Course in Clinical Psychology

ANNEX

**An exploratory study of factors
associated with therapists offering 26 or
more sessions of therapy**

**Christine Küchemann
(B.Sc., M.Sc.)**

February 2003

**Dissertation submitted in partial fulfilment of the Open
University Validation Service/British Psychological Society
Doctorate in Clinical Psychology
(Admission with Academic Credit)**

1 *It may help you to think about a specific person, although it's your decisions I'm*
2 *interested in.*

3
4 OK. Well there are two routes by which I end up seeing people for longer. One is, I offer
5 them at the outset more than twenty-six sessions, or twenty-six-plus sessions. Or, during
6 the course of treatment I end up in a well-planned, or a not-so-well-planned way, seeing
7 them for longer than twenty-six sessions.

8
9 *So what happens, what makes you decide at the outset?*

10
11 At the outset, it would be an assessment of complexity, level of disability, what role
12 cognitive therapy might have in helping them with that, versus medication or any other
13 kind of form of input, that the team may for example provide. And in rare cases I would
14 say, I would at the outset offer a maximum of thirty sessions. And I'm currently doing
15 that in a case series I'm doing with multiply traumatised ex-military personnel and
16 emergency services personnel. But I'm monitoring their progress in treatment in a single
17 case series. So, an example, I recently offered a woman who has multiple childhood
18 trauma, not CSA, but a whole range of childhood trauma, and has at least three Axis I
19 disorders. But is at the other hand also coping. I've offered her a maximum of thirty
20 sessions, but we in fact didn't do that, we decided to do something else. But I did offer
21 her a maximum of thirty sessions.

22
23 *You gave her less?*

24
25 I didn't...I mean in fact she only had three sessions in all; we decided that she wasn't
26 ready to do the cognitive work, and a CPN is seeing her to stabilise her a bit and to...

27
28 *And then what?*

29

And at that point we may then review psychological input, but that would also include reviewing the contract, which may not then be thirty sessions, but it doesn't include any emotional stabilisation.

What about the non-case series, the non-traumatised people?

Oh the ones...oh they're not always traumatised, but yes, at the moment it probably would be, because of the kind of people I see.

Yes.

Well there's...in history there are two routes by which I get to that point. I mean I haven't ... I've assessed them, and two people I'm thinking of in particular, one I offered twenty sessions to in, she's also seen by other members of the team, so I was just offering some specific CBT for her problems, and another patient where I offered fifteen sessions to, who is also seen by other members of the team in time. And in both cases I ended up seeing them significantly, for significantly more sessions, and often over long periods of time, but not necessarily very frequently. In one instance the reason that emerged really was because key workers disappeared, either because they moved on or because the patient didn't get on with her identified key worker being an RMO, and the contact with the team was felt to be incredibly important, because high suicidal risk... These are all, both, multiple admission patients, both chronic high suicide risk, and somebody needed to monitor him, for whom he was likely to show up, and who he was likely not to persuade that he was all right when he wasn't. And because of the relationship I established with him, and there is a degree of dependency...

So, you may see them for, sort of more concentrated block of therapy...

Yes.

60 *But then you change to monitoring.*

61

62 No, I change...well monitoring, support, a bit of problem-solving here, a bit of tinkering
63 with a, a thought or, interpretation of an event, his appraisal, there. But it's much more
64 low-key and I may at good times only see him every six weeks, and in bad times I end up
65 seeing him twice a week. And that really is, I've become really, I'm doing more generic
66 teamwork; the team has a belief I think, rightly or wrongly, that up to a point any good
67 team member takes some of its fair share of the team mess. And for political reasons it is
68 very usual for me to carry on doing some of that, but it has to be very limited, given my
69 role within the team. Now having said that, I think that's probably not the main reason
70 why I'm carrying on seeing him, but the main reason is that he has become very attached
71 to me, and that attachment in some sense is useful for keeping him alive. Because he
72 does come and see me, he doesn't just disappear from me. And good times, which can
73 last for four, five, six months, when he isn't...he's doing as well as he ever does, which
74 isn't very well, but...and we're kind of beginning to talk about maybe ending, handing
75 him over to one of our support workers and can then start an ending process, because of
76 his attachment, and, somewhere along that ending process, be it for a period of two, three
77 or four months, he ends up really ill again, and very high suicidal risk, at which, at that
78 point nobody thinks he can be handed over. And so we go round and round and round.
79 So I think there are two reasons for why I am still seeing him. The other person I've been
80 seeing for longer, who has also had multiple admissions is somebody who has done
81 phenomenally well, given her limitations of cognitive therapy, in the twenty sessions, that
82 we did work together. And, it was felt by the whole team that she could go further than
83 that and how unexpectedly well she'd done in relation to a particular part of her
84 difficulties. And that withdrawal at that point from therapy with me may threaten the
85 progress she's made. She's basically managed to go to university, in all of this being a
86 period of, well in total of about seven years, a 30-year history of psychiatric disorder, very
87 severe psychiatric disorder. So I've got her to go to university.

88

89 *So, I've heard you mention her.*

90
91 And it was felt at the time that if I pulled out, that that might...that she needed some input
92 to carry her at doing that. So, I suppose partly it feels that CBT is actually very important
93 to her, and that nobody else could fulfil that role in the team. But again there is an
94 element of concern about dependency and feeling that she can trust them. Which in the
95 past, not in my team but in the past she's had very poor therapeutic relationships, so to
96 have a, a good one is very difficult to end. So again I think there are two reasons, one is
97 probably a better reason than the other. But it would be confidently predicted by all
98 involved that ending would rock the boat very severely, no matter how well we've
99 planned it, and clearly we, given the concerns in these two patients that they might end up
100 in another admission or another suicide attempt. So, those were two examples of the kind
101 of multidisciplinary team decision-making, though it is partly, I'm holding something for
102 the team. And I suppose the other unplanned one was, me stumbling into, basically
103 stumbling into an area that I just had very little idea about, by which I mean ... I'm not
104 very articulate. When I assessed this man, my explosives expert, I assessed him as having
105 a severe PTSD and offered him twenty sessions of treatment but very severe PTSD, very
106 chronic PTSD. But at the time I had little understanding of the complexity of working
107 with people who had been subjected to multiple trauma. So I think in that context I set an
108 expectation for him and myself of a seventy per cent chance of treatability, but this isn't
109 actually all that difficult to treat on the whole, and lots of people get better and so forth. I
110 was treating him like a single event trauma. And partly that was because he was pulling
111 the wool over my eyes, he didn't tell me how bad it was at the time. But, so I got myself
112 into a corner where I realised after, in the process of twenty sessions, that this is an
113 entirely different ballgame, and it is an entirely different ballgame, I think that's been
114 replicated in the case series I'm doing now, but now I know what I'm doing, if you see
115 what I mean. But I had set the expectation I was going to get this man, hopefully better.

116
117 *In twenty.*

119 In twenty, which of course was no way on earth I could do that, because it took at least
120 thirty sessions for this man to tell me what was wrong with him, because of the trust
121 problems to show this particular population. And because I wasn't looking for it, if you
122 see what I mean, because I assumed that there was trust, and he was so distrusting that he
123 wouldn't ever have given the inkling that he wasn't trusting. Does that make sense? So
124 that was...so I got myself... So one of the reasons that I ended up in long-term treatment
125 is because I, I made, promised him, I didn't promise him but I gave him an impression of
126 treatability, and then we got all these obstacles. And given that it's also an area of my
127 interest and expertise, I became very curious about what was going on here, and did
128 subsequently do quite a lot of work in relation to that, and I think I've learnt great deal
129 about multiple trauma in the course of that. Now another...another factor in determining
130 that in the end we were going to do longer-term therapy was that, there was something
131 about him, a characteristic about him that I...it's not just being reflected by me, but
132 anybody who ever has worked with him, there's his GP, the bloke overseas, the
133 psychologist, the head of the [.....] Trauma Service overseas, saying there's something
134 very curious about him that makes you think this man could do really well. He has a lot
135 of strengths, which are very, which are apparent. So I think there's a mixture both of
136 thinking he can do something, but also I think, I was getting very disheartened in the kind
137 of patient-bashing kind of way of working, by which I mean seeing a lot of people really
138 fast, putting them back together again quickly, to some level of functioning, and then
139 discharging them, without ever feeling that you've done a really thorough job. And I
140 don't mind doing that, and I think it's realistic for them to be given the services, the level
141 of services we can provide and so forth. I was just getting very disenchanted with that
142 kind of way of working, and feeling quite burnt out by that. And I think in that context, I
143 really wanted to find out how far can I go in somebody where I know, I think I'm now
144 learning what I'm doing, I'm interested, and I think he has the resources to do it. I really
145 would like to get at least one person once in a while really better. So that was another
146 reason, I think it was actually personally a very powerful reason for doing that with him;
147 and it's not in the other cases. [pause] And that's [inaudible] really. There may have
148 been something as well as therapeutic niceties and the only way I could finally get his

149 trust was when I stop talking about very tight limits of treatment, I think that whatever
150 progress I might have theoretically made in twenty or thirty sessions, I couldn't have
151 made with him, if this was twenty or thirty sessions, because he would have thought he
152 was just, I was just part of the Establishment, and to screw him in the way that everybody
153 else had ever done. And that belief system, although maladaptive now I think reflects
154 real experience, rather than a paranoid state.

155

156 *Was it also something to do with his horrendous experiences?*

157

158 Oh, I think I felt immensely, and still do, feel immensely, immensely saddened by his,
159 overwhelmed in some sense by somebody who can have that much traumatic exposure,
160 and who is in some ways actually still doing quite well, and intact. I mean it's still a
161 miracle to me why he's still walking. But there is something, yes, about having that level
162 of CSA and adult traumatic experiences that is just never ending. And working with him,
163 that was the most difficult thing to do; not, each individual trauma is not something that
164 we have never heard about, is so horrific in itself that you can't stand it, it's just the
165 relentless nature of it, just one after the other after the other after the other, that at times
166 really really, somebody's got to do something for this man, he deserves better than this.
167 But having, having done all that work, I recognise that I can't stand, given that I am
168 interested in multiple adult trauma, I can't spend eighty sessions with every multiply
169 traumatised adult, is just completely ridiculous. So out of that work I have done a lot of
170 thinking, and clear planning, of how I can make treatment shorter, but it's still not very
171 short, I'm offering now thirty sessions, but how I can make treatment shorter. So I think,
172 I've tried to use it as almost a kind of form of CPD for me as a test for doing something
173 that might actually be very useful, I'm not sure. And that was I think my way of
174 justifying doing something that I know is not with...within the spirit of what we should be
175 doing. [pause] And it's very interesting. [pause]

176

177 *So you've, you've mentioned something to do with the patient that's, like attachment,*

178

179 Yes.

180

181 *Carrying on, and feeling that he deserves something because of someone's multiple*
182 *traumas...*

183

184 Mhm.

185

186 *...you've mentioned things to do with you, like it's interesting and you want to learn*
187 *more, and that the experience for you and you've been overwhelmed as well.*

188

189 Well I think in the one case, I think I do have an underlying kind of sense of, it's not...it's
190 not my responsibility, because I don't always...it doesn't always give feelings that ... I
191 think in relation to very hard luck cases, and all of the three I've just talked about are very
192 hard luck cases, they've had a really raw deal in one way or another, either from the
193 mental health services or from other organisations, but they have had a really raw deal, I
194 have some sense, a perceived sense of collective responsibility, that we ought to get in
195 that, we ought to do the best we can to get, to make amends. And I think, I think that's
196 not necessarily terribly helpful, that sense of responsibility. Because it makes it more
197 likely that I take...that it's difficult for me to, and... And it also could potentially be quite
198 a big burden. So, on the whole, most of the time I don't perceive it as such, but there are
199 bad days, and like recently when I had to threaten one of my patients with a Section,
200 because he was getting so ... feeling overwhelmed and burdensome, it took, it took a
201 good day to kind of, not feel shaken about having had that experience in kind of
202 threatening with Sections, which is something I don't generally do. [pause]

203

204 *And, something about the relationship between you?*

205

206 Well I have to be able to... I mean I think there is...I think in order to be able to do that, I
207 have to be able to empathise with the patient, and I know we empathise with patients, but
208 I mean real empathy; I have to have some sense of where this person is coming from.

209 And... But more importantly I think in all three, I have a sense of strength from them,
210 from the patient, that I have to perceive a sense that there's something intact I can use.
211 Because there are people who have been, have had terrible histories in whatever form,
212 and I haven't had that kind of sense of, 'Let me help you get out of there,' and I think the
213 difference is that I haven't at that point, rightly or wrongly, perceived that the person had
214 some kind of oomph left that I could use. But how good I'm judging that, I don't know
215 whether you would call it ego strength or...but, skills, a residual kind of strength I think is
216 a really important variable on the whole, I don't know. [pause]

217

218 *Yes, there are some people who seem to want to do something; there are people who are*
219 *humbling.*

220

221 Yes. Yes. It's a good word, without doubt people who are humbling. [pause] But I'm
222 also damn sure that there are some people who may be equally humbling if only we could
223 relate to them in some way, but that we don't click with them, whatever that might mean,
224 in the same way, and therefore they get a much more standard service. And I feel that's
225 probably inevitable; I think we need to watch out for it, that it's kept to a minimum.
226 [pause]

227

228 *And, then you've also mentioned that some, some of the decision-making or pressure or*
229 *call it what you will, is coming from the team, so it's coming from elsewhere.*

230

231 Yes, in two cases clearly, the pressure is coming from the team, because the patient is
232 being looked after with minimalish input from me. You know, there are no CPNs at the
233 moment running about, no psychiatrists who keep threatening to section them or keep
234 having to review the drugs again, keeping them relatively stable. I'm ... the team's very
235 keen on that, I don't want to rock the boat if I can help it. Although some members of the
236 team have more, a different view on what my role should be, and whether I should be
237 doing this or not. But there is also general pressure that is on every team member, that we
238 need to hold some of the really difficult cases, and do, do what we can in maybe an

239 unspecific way. Now for me, and if I provide non-specific support it will undoubtedly
240 always have a bit of a CBT flavour to it. And currently there is a significant dispute
241 within the team which is going to be discussed in the next review day, because it appears
242 that, the medics in the team do not see their role very much like that any more, that there
243 isn't, they don't hold difficult patients for the team. But then their absolute role is to
244 prescribe drugs. And that's, that's a perceived role that we think the medics have,
245 because that's how they appear to be at, and this is going to lead to a fairly significant
246 debate and seems to also be tipping the balance in the team so that everybody else has a
247 lot more, because we now have three medics, a lot more of those cases that need to be
248 shared out, which makes it harder for me to get rid of the ones that I've got if you see
249 what I mean. And will make the... It's a different role, depending on what role a
250 particular team member adopts, and how important that team member is, and that is
251 clearly an important function. If the team members don't do something, then there is a
252 fallback on any, on the rest of the team members. And I think in some sense if there had
253 still been A[...] B[...] [inaudible]...

254

255 *Well, he was a great holder.*

256

257 Exactly, I mean he was particularly unusual, but I probably would not be holding, at least
258 one of my patients, probably many of them, because he would be doing that. And he
259 would be doing it very well. So I think some of that comes from the defined roles that
260 people see they have within the team. Now whether they're agreed by the team is a
261 different matter, and I think that this, what's currently happening with the roles the
262 medics appear to be adopting that is not an agreed team policy, and will be addressed
263 however painfully that might be. [pause]

264

265 *I think know what you're talking about.*

266

267 Sorry, that's, that's clearly a problem that I think...that's a problem that all of the
268 members of the team face, including the psychologists. We're much more protected from

269 it because of the waiting lists and the kind of role that we generally have. So the vast
270 majority of my team colleagues who are not psychologists would have at least fifty per
271 cent of patients on their caseload of that ilk. And their role may be different, it may be
272 more appropriate to their role, but it is not entirely appropriate to them.

273

274 *Now what about supervision or line management, has that played any part in helping you*
275 *decide on sessions?*

276

277 Line management probably not greatly. Except that it was helpful to me to have Joan's
278 permission to do the work that I was doing with my explosives expert. And I think she
279 was fairly aware of the complexities of that. It was helpful; I don't necessarily think I
280 would have not done it if she had said, 'Don't do that,' but...

281

282 *Might have done it nevertheless.*

283

284 I might have done it nevertheless. I mean if she had said, 'You don't, and I refuse to let
285 you,' then, I probably wouldn't have, but, there's more or less approval, and I think the
286 approval has helped me turn that experience into something more constructive in relation
287 to the research I'm currently doing. And so line management I don't think has a major
288 role, but it does make you...being supported is always better than feeling challenged.
289 Supervision I think has had a key role in two of those patients, in terms of looking at what
290 I can do, and how far I can take it, and with my explosives expert specifically I've, on two
291 occasions, reviewed his case, and decided with my supervisor where I should go and how
292 much treatment I should offer reasonably, to make sure that it wasn't just being pulled by
293 my need to rescue. And I think there are good technical reasons why I should have
294 carried on, but it doesn't necessarily say that there isn't a need to rescue, which is a bad
295 reason. But just because it's a bad reason doesn't necessarily mean there's a good reason.
296 And so supervision has been terribly helpful, but with one caveat, that being supervised
297 by Z[.....], is incredibly, it's an incredible privilege. Z[.....] is a very good supervisor,
298 and I've learnt a great deal from her, but I think Z[.....] isn't working within the NHS,

299 so when I'm supervising, I might always have one eye on service delivery as a whole, and
300 how does that treatment of this case fit into the whole of the service in which this
301 treatment is taking place? I think Z[.....] is much more inclined to just look at the, the
302 kind of intricacies of doing CBT with this person.

303

304 *Yes.*

305

306 Which leads, doesn't lead her to ask me questions about, how long have you see them
307 for? How long are you going to carry on seeing them for? Those kinds of questions
308 which might, another supervisor might do, they might not, but might do. And she just
309 wouldn't do.

310

311 *And so, in keeping you going, or keeping you focused, or helping you stop?*

312

313 Oh, in terms of... Not in keeping me going, I think it's, it's helped incredibly in keeping
314 me very focused. Because one of the threats of doing longer-term work is clearly to lose
315 focus completely, and I think I've been there. Not necessarily very very long-term
316 treatment, but I have been there. And I think that on the whole the long-term cases I've
317 seen have had, because of supervision, a very clear focus. That might have been minute
318 steps I was trying to take; an example would be trying to get somebody ready for re-
319 living. That might in an average patient of single event trauma only take half an hour,
320 and somebody with very complex difficulty, that might actually involve lots of
321 stabilisation and lots of education and lots of kind of discussion about the fears and, and
322 the cognitions around the fears, which might actually take you ten sessions just to get
323 them there. But at least I knew what the ten sessions consisted of, and the goal was still
324 the same, so I think I, I remained actually incredibly focused, and I think I would have,
325 there would have been a significant threat of losing that focus if I hadn't, had regular
326 supervision. And subsequently, I think subsequent supervision is also very important.
327 Anything else?

328

329 *Is there anything else?*

330

331 No.

332

333 *So how have you felt telling me these things?*

334

335 I've felt like one of my patients might have. Well, fine, I have felt fine about it. But what
336 it does make me wonder is whether I need to spend a bit more time in thinking about how
337 I select people I may take on for long-term treatment. There sometimes is no choice, I
338 mean it's not me selecting but it's me being asked to do that; vanity. But inasmuch as I
339 am exercising choice...

340

341 *Well even there I suppose, when you think about it, if it's appropriate.*

342

343 Yes, well I'm actually... Yes, but, I mean clearly the others two I haven't seen for 86
344 sessions. But I'm just wondering about...my own variables at making decisions which are
345 not necessarily to do with straightforward up and down treatment decisions or demands of
346 a situation outside of my own feelings about something. I think one's feelings do come
347 into it. And just talking to you about it makes me aware that I need to very carefully
348 monitor, not necessarily the times when I may offer a lot of effort really, but the times
349 when I don't, by which I mean the people with whom I may not click in quite the same
350 way, who may still have vast needs, and to make...and just to see whether or not, just to,
351 to be a bit more cautious about what I'm doing. I'm not saying I should be offering them
352 lots of treatment, but to be a bit more overt in what makes me make those decisions. It
353 has to be said that I, I think, yes, I'm about to get rid of one of the patients who is
354 probably going to go to the H[...] Clinic in B[.....], and that will be a route for me to
355 stop seeing him. And I'm about to discharge the explosives expert. So... And I have no
356 inclinations to, at this point, to offer somebody else longer-term, very long-term
357 treatment, although because of my study, I will be offering people thirty sessions. [pause]
358 And it's not something I do annually.

359

360 *Only as much as annual?*

361

362 As much as annually. I think people I've seen for more than thirty sessions or so are
363 probably in total...six. And that's in 14 years. I mean spreads evenly through 14 years I
364 think. So I think, I don't think I would want to go down that route very often.

365

366 *Is there anything else you'd see differently now?*

367

368 No. I'm sure we'll be thinking about it at some stage, but right now I think it's fine.

369

370 *Well, shall we stop there?*

371

372 OK.

373

374 *Thank you very much.*

1 *I'd like to ask you why you've offered a patient, or more than one patient, twenty-six or*
2 *more sessions of therapy, and it might help you to think about a specific person, but it's*
3 *the decisions about giving that number of sessions that I'm interested in.*

4
5 So, how I reached them?

6
7 *Why were they given that many?*

8
9 And I think that that is...there are different decisions, different reasons for all of, for each
10 of them, as much... So... One person I suppose was about the fact that we seemed to
11 have engaged, and she seemed to have been making some use of cognitive therapy, but
12 she had a lot of day-to-day problems that arose, and quite severe depressions that came
13 extremely quickly. She was diagnosed with a slightly, not quite bipolar affective
14 disorder, but a kind of lesser version of that, so more, more major recurring mood swings.
15 And so that our overall goal, was more about trying to look at beliefs of hers, and to
16 explore and change some of her extremely negative beliefs, was upset on a day-to-day
17 basis by difficulties, such as her depression which was caused by, and which was
18 precipitated at that moment by, a lot of physical problems for example, or not getting any
19 benefit, or a neighbour's child dying, committing suicide. There are a number of kind of
20 day-to-day just events which upset her mood and the course of therapy. So she was quite
21 well engaged with us, and actually it was quite successful [inaudible] that we met.

22
23 *At what stage did you decide to carry on?*

24
25 Well I think we just kept reviewing every, about eight sessions. We had originally I think
26 with her, I think that we'd, it's difficult to remember but I think that we'd originally
27 planned to have five sessions of mood management and thought records sometimes, and
28 that seemed to make sense, and so actually from this original five we ended up having,
29 I'm sure it was more than thirty. And so that was one of the reasons that our work was
30 kind of always going sideways, because of these crises.

31

32 *How did you...*

33

34 ... fire-fighting.

35

36 *What made you stop, with her, what made you stop?*

37

38 [pause] I think we had agreed to get to a certain point, and we did a historical review, and
39 things were actually going much better, but I wonder if I was also reducing my sessions in
40 that team, and so, it was maybe easier to think about meeting (?) her. But I know that I
41 continued working in that team, so, for quite a long time after that, so I'm not...I don't...I
42 don't think that was a major thing; I think it was that we had agreed to do a certain
43 amount of work and to look at bits and pieces and that sort of thing. And actually what
44 was really helpful for her was doing a historical review, and getting another way of
45 looking at her past experiences, which she'd developed all these beliefs on, and actually
46 she decided that from then it was really more a question of her trying to practise these
47 things and keep them all going, there wasn't necessarily anything new for us to do.

48

49 *So partly it came from her?*

50

51 I think so, yes. Yes.

52

53 *Yes.*

54

55 And then there's another person who we, again with all people I think I've had we've
56 reviewed continually, but the fact that this first, this other person was someone who I
57 thought was engaging with the model, and I kept thinking that she was making changes,
58 and she was extremely, extremely pissed off, and depressed, and distressed, and
59 depressed. And, and I just kept thinking that it would help, (laughs) and it could help,
60 and that we were making progress, but actually, we weren't. (laughs) And, we got to

61 thirty sessions, just we, I decided on discussion with Y[.....] that I really had to end, that
62 she wasn't going to be able to benefit from it, and she'd had a fair go, it wasn't making
63 any difference.

64
65 *[inaudible]*.

66
67 And so that was quite different from the other woman. Sorry, was there...?

68
69 *But why at that particular point, was there some particular reason at that particular*
70 *point?*

71
72 Because she'd had so many sessions, but...

73
74 *Twenty-five must be the same as thirty, or twenty, twenty.*

75
76 I think at twenty things were looking a bit better, so, I think, I think I was lulled into
77 thinking, well just a few more. And then, because of the situation which I'd got myself
78 into really, we had to have a very planned end, and that meant stating something that was
79 reasonable, which wasn't just two sessions from then. So that's how it ended up with
80 there being thirty, was that it was kind of another five sessions or something at that point,
81 and really making myself think about where we were going and what progress there had
82 been. But that was a really tough one, I mean I was...it was really tough to stop with her
83 actually. And...

84
85 *Why was that?*

86
87 I don't know.

88
89 *What was it...*

90

91 She got... I don't know. I think she got under my skin somehow, (laughs) and... And I
92 think it was, it was something about the fact that, I felt like she should have been able to
93 make more progress with it than we had, which might not make sense, but... So in a
94 sense I guess I was thinking maybe I'd done it wrong, that if I could just get her to
95 understand things better, or if I could put things differently, and...we might, we might get
96 somewhere. There was also, I think at probably session twenty, I think she'd talked about
97 a lot more than she had before, and was really questioning a lot of things in her life, like
98 her relationship and her situation, and...which were things actually I think were really
99 maintaining her problem, and I think that was a huge amount of work.

100
101 *So you felt hopeful at that point?*

102
103 Yes, I think at that point I did, and then I think she, she decided, although maybe not
104 explicitly, that she, she wasn't going to be able to make changes to those things, she
105 couldn't even emerge for example, and things slid back. [inaudible] much more clearly
106 than I think it was, but her having made, her being constantly unable to do things that
107 we'd agreed that would be helpful perhaps to. And finally coming to the conclusion that
108 not going anywhere. So something about chronicity, or chronicity, severity, distress,
109 keeps you going. Maybe from the outset you can kind of expect not to be able to deal
110 with in ten sessions. You want to, but I think those two people make...were kind of quite
111 different decisions, in terms of how I...you know, at what point we got to, and the
112 reasoning was quite different as to why we got to thirty sessions. Though someone else
113 who I'm sure she went to thirty sessions, and made very little progress, but some of the
114 difficulty with... Did we have thirty sessions actually? I can't remember now if we only
115 had twenty. It'll be someone that you will remember my talking about someone who,
116 whose dog ate her homework, do you remember? And I just didn't trust what she was
117 saying, just didn't really believe her. And also at the time, because she was saying things
118 like, 'The dog ate my homework,' she may well have done, if there was a dog.

119
120 *Well if she was X[.....], she might have done.*

121
122 (laughs) Even without a dog. (laughs) The rabbit ate my homework. (laughs)

123
124 *Or the [.....] destroyed her Filofax.*

125
126 Really?

127
128 *And then, the dates didn't matter any more to X[.....]. (joint laughter)*

129
130 And she cancelled an inordinate number of sessions, which is maybe why I've got it into
131 my mind that she had thirty sessions, because I think I might have started to count the
132 sessions that she didn't attend, which doesn't really fit with what you're talking about.

133
134 *Mm.*

135
136 And I can't remember exactly how many she had, we had, but she had a lot. But as I say,
137 I can't actually remember whether there was twenty or thirty. It was easily thirty, if we'd
138 agreed to count the ones that she didn't attend. That was one way of dealing with her.

139
140 *So what was different with her?*

141
142 That I felt that we needed a contract about what a therapy was...what therapy involved,
143 and what was necessary for that, and part of what was necessary for that was attending.
144 (laughs) Which seemed quite reasonable at the time.

145
146 *So, you're saying that sometimes you know from before you see them, right at the*
147 *beginning, that ten isn't going to be enough...?*

148
149 Well I feel like it's not going to be enough. I think I always start out telling people
150 there's going to be ten sessions, but, yes, yes sometimes we, I think I perhaps started out

with both people, because of how distressed they are or how long their problems have gone on for, I mean there's not much evidence for that. Actually it feels like a lot to have to do.

And with others, you don't think that at the beginning, but then, it still carries on?

Yes. And that's about it having been helpful, and not wanting to end too soon, in a sense. That people have been able to make use of some bits of work, and it would seem, it seems reasonable to try to extend beyond working on their here and now and negative automatic thoughts to working on making bigger, not necessarily bigger, making other changes to their beliefs and assumptions and behaviour. And I think that's when it's been more sessions as when I'm trying to look at, maybe trying to get people to look at making quite huge changes in their life really, which require quite a considerably different way of acting and behaving. That's when I offer them a bit more. And ten sessions to get someone from where they start in ten sessions to the point of changing their whole belief system that they've had for forty, fifty years, with huge amounts of trauma and abuse in between, just doesn't seem reasonable. [pause] But again that doesn't apply to everyone, there are very different people. There are people for whom their history is suggestive that... [pause] that chronicity but, you know, that there's a lot in their past, where there are others for who it's the level of distress when you first meet them. And as I said to you the other day, I haven't kind of thought it through, and I haven't discussed it with other people, and so suggestible that when someone else says something, I think, oh yes, that's what it is. But I haven't thought about it. Haven't thought through ideas. (laughs)

That's quite all right. Sometimes those things are the most interesting.

(laughs) But it's very much person-specific. I mean I think it's really hard to say, 'Well these are the rules, and this is why I do this,' because there are plenty of people for whom my expectation of how many sessions they're going to need is completely inaccurate, and that was in fact what started me on the whole Research, I don't know if you remember

181 this, was that it was someone that I was seeing in the Central service, who had a terrible
182 past history of abuse and had had to give up her children, all children had been taken
183 away from her, or, at different times, and gone through hideous, hideous legal things in
184 relation to her children. And was very depressed when I first met her. And within ten
185 sessions she had made an enormous change, which looked like it...and was maintained in
186 follow-up. And there was nothing that I could have said about her at first meeting her
187 that would have made me think that she would be able to make those changes, huge
188 changes, in such a short space of time. And that's what got me started on the whole
189 Research, was thinking about, well what makes things better for people, as opposed to
190 what makes things worse? I mean it's easier to just look at things like chronicity and
191 levels of past history of abuse and whatever, and to assume that things will be worse, but
192 actually, why do things, then get better so quickly? And that's, that's what started the
193 whole thing, which of course I can't follow up. But that was what, that was fascinating,
194 the fact that she did get better so quickly, and it was so well, seemed to be so well
195 maintained. So as I say, it's completely person-specific, and what you think at the
196 beginning isn't necessarily what then, then happens. And with her I think it was
197 something about that psychological mindedness, she was fantastically psychologically
198 minded, although not particularly intelligent, which actually was probably to her
199 advantage. And had... Yes, the psychological mindedness I think was the main thing
200 with her. But also I think was able quite easily to access much better, a better belief
201 system, self-belief system, and it was much more readily available than I think I had
202 thought at first instance. And I think if I, if I go back, if I go back, the woman with whom
203 I had thirty sessions and at that point decided to have to, you know, well not have thirty
204 sessions, planned to end at thirty, she in fact was not psychologically minded, and I kept
205 thinking that she could be (laughs), but I think she had an enormously medical model of
206 treatment and was probably quite compliant in some things, and so would do some things
207 and question them, but then seemed to understand them and believe them, but then
208 actually would come back the next week and say, 'It didn't work,' or say something that
209 would lead me to think that she just expected it to work by osmosis or to work in the way
210 that a pill would work. She was also having a huge number of changes in medication

211 throughout the time that I knew her, and a lot of side-effects of the medication were
212 resulting in her gaining weight quite fast actually, and so she was becoming extremely
213 disabled by her weight gain as well. So that was constantly offsetting any work that we
214 could do, because she was getting these two different messages all the time, one about
215 medication being a way forward, or the way forward, because they were constantly
216 changing it, but also not a very helpful way forward because otherwise it would have
217 worked, and me saying other things. And that then being hampered by, on a very basic
218 level, her physical inability to do things that you would want someone to do with severe
219 depression.

220

221 *It's the woman who was then seen over in the other department?*

222

223 Yes, it is, it is. I forgot that she went to the other department. Did she complete
224 treatment there?

225

226 *She did complete it; she made some minimal changes, which were not expected to hold up*
227 *at follow-up.*

228

229 Apparently she's now doing very well with a psychiatrist, with C[...] D[...] in fact.

230

231 *Yes, she was seeing him in fact. It didn't seem at all helpful and she...*

232

233 Well, apparently, well, when I last checked, which wasn't that long ago – yes, I'd
234 forgotten that she'd done that – she had said he's wonderful apparently, and he's someone
235 who encourages dependency I think.

236

237 *Yes.*

238

239 So, which [inaudible]. (laughs) Not that that didn't go around [inaudible], you know.

240 And, he... Yes, so that's, that's...and I think that's interesting. So there is those, and she

241 did complete treatment, so you know, there's something, there's something about
242 encouraging hope in a therapist I think. Although I don't think that's why she got
243 referred to the other dept. But you just...but there was something quite intact about her
244 that you felt that she should be able to move forward and get through that, but you know,
245 I'm completely repeating myself, and was different from the first person I was talking
246 about, in terms of her being able to make progress, and really benefiting from using a
247 more structured approach; in all of her crises still I could be much more structured than
248 for example her meetings with the CPN, which are actually very unhelpful. So it seemed
249 reasonable that I offer her support at various points along this time, because she was
250 doing things, she was doing a degree and stuff, she was a mature student, went back to do
251 a degree, and that seemed reasonable that I see her through that, and help her with her
252 study skills and all that kind of thing, rather than passing her off to a CPN, although I did
253 try that and it was unsuccessful and she kind of relapsed. So when I started to see her
254 again I then helped her through it (laughs).

255
256 *That's not part of the thirty you were talking about before?*

257
258 Yes, it is, yes.

259
260 *Right. So that's interesting. So, then come back, and then it might be more supportive.*

261
262 Well she didn't leave the whole system, and what we'd agreed was that, because of the
263 nature of my sessions, and that we're more problem-focused and we were trying to look
264 at her beliefs, she was about to go through this very stressful period of time of doing her
265 exams, but it probably didn't make best use of her or my time to meet with me. So that
266 we agreed that she would meet with the CPN during that time, and...but actually, I think
267 they just didn't gel, or the CPN I think was not structured enough or didn't...just didn't
268 get her to use any of the things that she had learnt with me in terms of questioning her
269 thinking and all the helpful behavioural things that had worked before. And so she, she
270 relapsed, and at that point they asked me to get back involved, and so that I then, I then

271 just saw her through to the end of that, or she had to re-sit it or something, I can't
272 remember. I think, I think in fact what she decided was that she wouldn't take her exams
273 when she was supposed to, and that she would take them a few months later. So having,
274 her having decided to do that when she was meeting with the CPN, and I started to meet
275 with her again, and then just held onto her, so we... So we were constantly thinking, I
276 mean at least thirty or so sessions, which may well be many more than thirty in fact
277 (laughs), were over quite a long period of time, I mean it was over...no, it must have been
278 a lot more than thirty. It was over two or three years I think. I'd have to check the notes
279 to see exactly how many times I saw her.

280

281 *Not seeing her every week, certainly not, not in the later phases?*

282

283 No, and it would change; there were times when I would see her weekly, and there were
284 times when I would see her monthly. Or, there was a time when I didn't see her at all
285 over the summer, because she had her daughter in, and it was just easier not to, so... So
286 that was three or four months I didn't see her. So...

287

288 *So, sometimes there's something about the patient, some things coming from the patient*
289 *that makes you carry on or extend the therapy.*

290

291 Mhm. Yes.

292

293 *Sometimes...sometimes the system asks you to get involved again.*

294

295 Yes. Well... Yes, that is true, although with her it wasn't, but yes, that is true, it made
296 more sense for me to do that work, I hadn't originally planned to do, so yes. Yes.

297

298 *And, sometimes it's you, or...*

299

300 Yes.

301
302 *...this person should be able to do it.*
303
304 Yes, if only I could find...
305
306 *[inaudible]*.
307
308 ...that particular way of putting it. Yes.
309
310 *Something about the relationship between you with some people, that makes it carry on?*
311
312 Well always. (laughs) But I think that's also to do with the hope, that if I didn't have a
313 relationship with the individual, then I might not be as hopeful at all.
314
315 *There's also guilt sometimes, carry on though guilt or some...?*
316
317 *[pause]* Yes, and...and the person...I don't know what to call her, the one who went to the
318 other dept.
319
320 *W[...], yes.*
321
322 Yes. I think that was, that was hope and guilt together really, they're sort of oscillating.
323 (laughs) Which was very powerful. It was extremely powerful actually. And that's what
324 I mean about getting under my skin I think. It was definitely, it was definitely both, and it
325 was both at different times. But guilt, but just guilt, I'm not sure. There's someone else,
326 but again I don't know how many sessions we had, but it was certainly more than the ten,
327 I'm not sure that it would have been more than twenty-six, who may well have been more
328 of a guilt type of person, and I (laughs) with him, I decided to refer him into the Central
329 service, and to see if someone else would do a better job. So I think that would be my,
330 my personal, usual route with someone that I didn't have that hope with, personally,

would be to try to get someone else to check it out, and that might be to do with the relationship as well. The person I'm thinking about is someone who, how I just couldn't really ever fathom what was going on, exactly what was going on with him. And again, he seemed to give me some ideas that he was making use of the sessions, but then ultimately just didn't seem to do that, and with him I think because I just didn't have a clue what was going on, it was much easier to say, 'I think that we should end, but I'd like, you know, how about seeing someone else?' to see whether that would be helpful to continue.

Anything about why you chose that particular point at which to make that decision?

Well I think that will have been a session limit thing, much easier to say, 'Well, we've had fifteen sessions,' or whatever, 'and I really can't offer you any more in this service.' Much easier. And it is terribly unfair, that one person should have that, although, is it unfair? It is, if you, in a black and white way it's very unfair, but I think it's also, it was fairer to him to not continue with me. And I guess that's something you're always weighing up, is about, well the whole thing about whether they can go further with what you're doing with them, in that relationship, at that moment in time.

Mm.

If they want to get better. You can't make the people go any further than (laughs) they want to... But with the first person, or the person we're talking about mainly, she definitely had an idea how she wanted things to be, and as I say, given everything about her, it was quite unreasonable that that would happen within ten sessions.

And what about supervision, did that play a role at all in, either encouraging you to carry on, or to stopping you, focusing you?

360 Yes, certainly, both. I think that... Well I think it's much easier to drift with people if
 361 you don't tell people what you're doing (laughs), or if you haven't that supervision, you
 362 know, for a while. But it's also possible to use supervision with other people where you
 363 seem to have made this progress, how about trying to go a bit further? And with these
 364 individuals, I mean, they are quite a while ago, because I've had, because I've recently
 365 had more short-term placements in a sense. (laughs) So it's hard to...of course I'm
 366 currently in The Second Team, I was looking at how many times I'd seen people, and I
 367 haven't quite got twenty-six but I'm close to twenty-six.

368

369 *And that's been less than year.*

370

371 Yes. Yes. [inaudible] twenty-six [inaudible]? Yes. It's much easier to go on with people
 372 if you're, if you're not having detailed discussions with someone else. Well I think it's
 373 also easier to go on with people if you're having supervision with someone who's not
 374 directly involved with the service, with your particular bit of the service. So I'm having
 375 supervision with U[...], who in a sense doesn't mind whether I see someone for six
 376 sessions or two hundred (laughs), you know, it wouldn't really be her position to question
 377 that. What Y[.....] and I and whoever was working in The First Team agreed at one
 378 point was that we would have a... Oh my goodness, I've completely forgotten about
 379 someone else, sorry. We did have a review of who we're seeing and how many sessions
 380 we'd had with them, as a kind of peer pressure thing really, to get us to really question
 381 how many sessions we're having. Because our waiting list was so huge, as I'm sure it
 382 still is. And that was really interesting, because it really did make you focus on exactly
 383 what you were doing, and why you were having so many sessions, and, and with M that
 384 was certainly crucial in my actually ending when I did, that, I could quite possibly have
 385 drifted on and on and on and getting nowhere, and actually being, quite unhelpful. And I
 386 think with her it was actually really unhelpful to have gone beyond the ten sessions, but
 387 that's [inaudible] really unhelpful thing to have done.

388

389 *And of course she had a different therapy where it was definite that it was going to stop,*
390 *and did.*

391

392 Yes. Yes. Yes.

393

394 *So what's the one you've just remembered?*

395

396 Someone with an eating disorder, who I saw for ages and ages and ages. And I was
397 worried about it before fifteen sessions I think. And, but that was actually encouraged in
398 a sense by supervision, so that's what I mean about supervision being helpful both ways,
399 because it was the first time that she had engaged with anyone to any extent, and it
400 seemed to be helping her in keeping her out of hospital. And so that was, that was
401 supported by the service.

402

403 *Was that a team or a Central one?*

404

405 It was a team person. All the ones I'm remembering are team people, but I also, you
406 know, for the first few years only worked in a team.

407

408 *[inaudible].*

409

410 Mm.

411

412 *What about [inaudible] must have been.*

413

414 Mm. It was, that's right, it was at the very very beginning, that's right. And then, and
415 then Y[.....] dropped his ward sessions, so I had three ward sessions and seven team
416 sessions, and so, yes, so that's why I stopped the Central work. So, and that was probably
417 about a year into it. Because I basically... In fact there is another, there is a Central
418 person who I saw, but I can't remember how many sessions I saw her for. And I

419 struggled with her. And probably drifted on because I was a bit scared of her. (laughs)
420 When I was newly qualified and didn't have the confidence to say I don't think this is
421 going to go anywhere. But, I think it was only about fifteen sessions actually; just felt
422 like two hundred. And I've since heard about her from E[...] F[...].

423

424 *And so she's doing the rounds still?*

425

426 No, I think she had about six years out, but she's come back in, yes.

427

428 *So being newly qualified can also lead to more sessions?*

429

430 Depending on the person, I think it may have done. But there are so many, now, as I say,
431 there are so many environmental factors that make it difficult for me to see people for
432 longer than two weeks – well, right now, a week. (laughs) But things like that changed
433 all the time, so, that's not very helpful to you.

434

435 *It is.*

436

437 But it does keep, if you know that you're going to be leaving, then, it does make you
438 much more focused on what you're going to do and much more much clearer about how
439 many sessions you can have, and what you're going to do in the time, what's reasonable
440 in that time, and... But what happens to those people, I don't know. You know, if you
441 then end your contact with them, like if I had had not seen that first, the main person I've
442 been talking about for as long as I did, then, and got her to that point, what would have
443 happened to her? And I'm pretty sure that she would have just come back in to the
444 service. She would have done anyway, in fact I know now that she has, she has come
445 back into the service again, because she's had a hysterectomy that's gone wrong, and so...

446

447 *Some people have bad luck.*

448

449 Well precisely. And she's had an enormous amount of bad luck. And that, one of the
450 things that I, one of the reasons that I had more sessions, I'm saying ups and downs, one
451 was her health, and she'd had problems, and had had an operation but hadn't had a
452 hysterectomy, but clearly has a lot of physical problems. She also broke her foot, and
453 things like that. You know, there are things like that got in the way really. (laughs)
454 Which is always the case. And there's someone now here I'm seeing at the moment, and
455 if I wasn't leaving I think it would...it could drift on. There again I'm not sure that it
456 would be helpful to do so, I think that's something I would certainly take to supervision,
457 if, just to think about but she's saying, that it's, it's...our sessions have been really
458 helpful, much more so than the CPN sessions, that she likes the structure, and that she's
459 been able to talk to me in a way that she hasn't been able to talk to other people, because
460 she felt like she was burdening other people. Whereas, she...she said to me, 'But I can
461 tell you anything and you're not going to take it, you're not going to get upset.' (laughs)
462 Which she was clearly valuing. Although what she said, what she...what she, she also
463 said was, 'I can tell you anything, you wouldn't care. No I don't mean that.' (laughs)
464 So... But she's a very vulnerable and very damaged person.

465
466 *So, an obvious factor in giving more sessions is, you're available to give more sessions.*

467
468 But I think, and I think that being available is kind of what we were talking about, and
469 does it mean physically available, does it mean emotionally available, does it mean the
470 service is available? I think, I think all of those things are critical. Or is the patient
471 available? (laughs)

472
473 *Yes.*

474
475 To give someone else a go.

476
477 *Is there anything else you want to tell me before we finish?*

478

479 I'm sure I could witter on for ages, but I think I'm repeating myself now. And I'm sure
480 there'll be something as I leave the room and I'll I think, 'No, that's what it's all about.'

481

482 *Bound to be.*

483

484 Mm. Mm. And I think the main, the main thing is that there aren't any hard and fast
485 rules; there don't seem to me to be any hard and fast rules.

486

487 *How's it felt, talking to me?*

488

489 Fine. I think it's nice to, to think about some of these people.

490

491 *Anything you would see differently now?*

492

493 [pause] I think what's occurring to me from talking to you is about, there is something
494 about supervision, and it's tied to the service I think, and that when you're kind of lower
495 down in a sense (laughs), more newly qualified, and I see it as being my responsibility in
496 The Second Team for how many sessions V[...] has with clients, but I don't... But no
497 one's doing that with me really. V[...] and I, I mean I do that with me mainly, and then
498 have supervision about the quality of the work, of whether I could do something
499 differently, but not really those fundamental nitty-gritty things about the, what the service
500 can cope with. So I think that that, yes, that's quite interesting, and that would be useful
501 to think about. But other people at...that level...

502

503 *Yes, I sometimes think of that as management supervision...*

504

505 Yes.

506

507 *Case management supervision.*

508

509 Yes. Which I haven't been having.

510

511 *Supervision is just for clinical stuff that you have with U[...].*

512

513 Yes.

514

515 *And case management is what I think of as bringing to the...my line manager type*

516 *supervisor.*

517

518 Yes, it is.

519

520 *Which is what I've used X[... ..] as; I've never had supervision from her, I go to have*

521 *case management.*

522

523 Yes. And I haven't been having that recently. And in a sense it hasn't been that essential

524 in The Second Team, because it's been a short-lived thing and The Third Team was a

525 short-lived thing. But I, I wonder whether, and I've been looking at the waiting list and

526 thinking about it, and wondering whether The Second Team has suffered as a result of

527 that, in terms of how many people I've been able to see in my time there, how many

528 people we've got on the waiting list, how many people have left it, sort of thing.

529

530 *Yes, actually that is another factor isn't it, where you are in terms of responsibility, and*

531 *the number of sessions, because you're looking at the service as a whole, not just at this*

532 *patient, which, someone low down might only be thinking this patient..*

533

534 Mm. Yes. And with Y[.....], and one of the reasons that we agreed to have that open

535 discussion of how many people...not...who the people were that we were seeing and how

536 many sessions we were having with them, was because, I've got...we've got...I personally

537 felt, and I might have said this, to Y[.....], who might not remember, that we had agreed

538 that he and I would have a kind of peer 'Twerps' thing, and I would do that, but I became

539 increasingly aware that Y[.....] wasn't doing that, although we had agreed that that's
540 what would happen, so I stopped doing it, and...(laughs) and just let it drift. And I think
541 he let it drift as well. I mean this is going back some time, so I can't talk about how it is
542 now. But, and I think that that is a big factor, that sometimes it seemed quite legitimate
543 to see people for a longer period of time, but actually I think that quite often you do just
544 drift, and that's [inaudible]. And so that you need those conversations, you need that kind
545 of line management checking in a, and maybe in a supervision type way, rather than a
546 managerial way, I think, it just felt too one-sided, well if he's not doing it, why should I?
547 (laughs) And I think, and that was helpful.

548

549 *Actually it's something for our meeting next week.*

550

551 Yes, possibly. Because I think the peer, our peer supervision groups could also offer that,
552 I think that could work, in that environment, in that setting. And when it's one-to-one
553 and it's clinical supervision, it's.....

554

555 End of Recording

1 *So, I'd like to ask you why you've offered patients twenty-six or more sessions of therapy,*
2 *and it may help you to think about specific people, and it's your decisions that I'm*
3 *interested in.*

4
5 Right. The reasons I've offered patients more therapy is that I felt that less than that has
6 not helped them with the goals that they've come to me to work on. Often it's a case of,
7 they've started a process, and we're aware of the fact that it really is very much starting.
8 The other very relevant factor with my...

9
10 *Very much starting...?*

11
12 Starting a process of change, and, it's right at the beginning, twenty-six sessions for the
13 patients I see is really right at the beginning; for many it's a question of even getting them
14 to acknowledge that they have problems that they want to work on and change.

15
16 *Right at the beginning of change; not that you decide right at the beginning of therapy, or*
17 *both?*

18
19 Quite often I do have a view already that this person is not going to be able to go off into
20 the wild blue yonder with less than twenty-six sessions, but I try to make it such that I'm
21 aware of that question all the time, and it's a question of, that they haven't managed to
22 make the changes within that time, and therefore we need to continue making a longer
23 relationship. The very important thing is that it's often, ten sessions could be just trying
24 to make a relationship, before we even start to address what they want to change, because
25 they come often so poorly motivated. Often they're brought by relatives, and it's a
26 question then of actually getting on their side. And if I was seeing them for ten sessions
27 or twenty sessions, they could rightly say, 'Well, you persuaded me that I need to come
28 and see you, and I've actually got to the point of trusting you, and now you're telling me
29 to go off and do it on my own.'

31 *Well one thing that puzzles me about that is, you seem to be accepting their goals rather*
32 *than maybe your goals, or joint goals. And the other thing, from the previous interview,*
33 *there was a slight contradiction, because you said, you can tell in the first six sessions*
34 *whether people are going to be able to change or not; but here you're... And you also*
35 *said in that one that you often need a lot longer before people trust you.*

36
37 Right. The six session things refers to the research for the treatment of bulimia, and it's
38 really straightforward treatment of bulimia nervosa using the MN approach, and it refers
39 to the fact, just using his approach, his straight approach.

40
41 *How many sessions does he offer then?*

42
43 He offers, usually, well the standard approach is sixteen sessions, but if the change has...if
44 things haven't started to change with six sessions, you can predict that it won't occur
45 within the sixteen sessions. So I was very specifically referring to that very
46 straightforward approach to bulimia.

47
48 *Mm.*

49
50 OK, so what was the other bit? Let's think. [pause] The truth is, because of the nature
51 of the patients we see, who are tertiary referrals, I do often have a good idea right from
52 the beginning that they will not respond to short-term treatment, so you could say, I am
53 prejudiced to look, to offer them more.

54
55 *It's an assumption.*

56
57 Yes, it is, before I start treating them. Because they will have had treatment with other
58 people, or they will be very unwell, and particularly the very unwell ones often are in
59 denial, and therefore, people who are in denial about their problems, I mean they'll
60 acknowledge that there are some things that go along with it, but they will deny they have

anorexia, which is mainly the problem, it's really a case of trying to make a relationship with them, and that can take a long time. And in terms of what we used to do in psychology was offer ten sessions; I could easily spend ten sessions just trying to hang in there with them before we've even started to make changes. Sometimes it's then motivating them, those very unwell ones, to have in-patient treatment, or day patient treatment. But they don't begin to make a connection.

The other thing was goals, that...their goals.

Ah, that's right, goals, their goals versus joint goals or my goals.

Are their goals realistic?

No, but particularly... Not...no, not necessarily. But, their goals... They often want to be without the symptoms of anorexia without, without eating more for instance, so therefore, the goal of being without the symptoms is realistic; it's the means in which you achieve that, and often it, we just have to accept their goals and the terms that they put them to start with, so we at least, it feels as if I'm on their side, and then we can start and look at how we can achieve those goals. It's very, it's not...I never work with my, just my goals. Clearly... Clearly they have to be joint, clearly... If someone for instance comes with bulimia, and it's quite common they will say, 'My goal is to lose weight,' then I will say, 'Well actually I don't feel that's something I can work on at present. That is up to you; I don't see how you can even look at weight loss or what the normal weight is until you eat properly, so you then see what your natural weight is, and then that's your decision, whether you want to lose weight or eat less. But I'm not about offering a therapy to help people lose weight. But I can help you discover what your normal weight would be with normal eating, and then you can make a decision about that afterwards. I can discuss that with you afterwards.' So I will always try and connect with their goals, and their goals, the way in which they think they might achieve them might contradict the way I think about it, but I would have to, we would look at that, gradually as it were, according to

91 when they were ready to do that. Because if they come and they...the worst thing that
92 happens with anorexics is that, other people have told them they need to change, and their
93 sense is that anorexia has been a solution to, to many of their difficulties, so if you go
94 straight in and say, 'Right, the first thing we need to do is sort out and take this anorexia
95 away from you,' then, you undermine any relationship right from the beginning. So I try
96 and establish what things they do not like about their anorexia, at the same time
97 acknowledging that they adopted it for a good reason. Does that make more sense?

98
99 *Mm. So, it sounds as though most of the time you know right at the beginning if there's*
100 *going to be a longer therapy.*

101
102 Yes. That, realistically speaking, now with the group of patients I work with, I would
103 know that.

104
105 *And before?*

106
107 But before, it would be more reasonable to say that, if I had a mixed group of patients, I
108 would then, in terms of the length and severity of their difficulties, I would assess that as,
109 to what was happening, say, within the first ten sessions, or six sessions; we often think in
110 terms of six sessions, review. Clearly if you can treat people in less sessions, it's, it's
111 more helpful to them, although actually I don't find that as a satisfying way to work; I
112 prefer to be involved with longer term relationships with people. And in terms of, we
113 work with CBT, in terms of, the shorter interventions are based at working at a thought
114 level, and if people can use that and change their behaviour, then, I would help them do
115 that. And I would judge whether that was bringing about sufficient change within six
116 sessions, twelve sessions, eighteen sessions maybe. But if, if we were coming up against
117 a brick wall, and they were... Quite often you get that sense, people say, 'Well I know, I
118 can write it down, I can write it on thought records, or I can give you reasons for this
119 happening, but it's not affecting how I feel, and I've always felt like this from the very
120 beginning'; it's that kind of, referring to sort of, core beliefs I think that makes you sense,

121 this is not going to be something we're going to shift in, without getting involved with
122 longer-term work.

123
124 *So when do you decide to do, one, thoughts, and when you do decide to move on to core*
125 *beliefs?*

126
127 Well, there could be the correct answer, and the answer actually occurs...

128
129 *No, your real...your real answer.*

130
131 I...I mean I actually think, you develop quite an instinct, don't you, for, for the way people
132 present. You know, if they are...if they take to thought records, and they use them and
133 you get the sense that this...that there's an aha experience for them, it's actually making a
134 difference, you can actually, I reckon you can assess that pretty early on. OK, give
135 them...if you give them five or six sessions to get into it, but then if they're then starting
136 to use that and come back to you and say, 'Actually this affected how I felt about the
137 things, I feel, this feels differently,' even if it's a little bit, you can just get that sense that
138 it's very different to people who say, 'Well I can do that and fill out your forms forever,
139 but actually this makes no difference to how I feel. I still believe that I'm a bad person.
140 OK, I can see logically that being able to do this that and the other...' And I think...I
141 mean it's almost a, just, you listen to what they say, and it... I rarely find it difficult to
142 make that distinction. And it's that kind of... And especially if they're bright or
143 whatever, they will often fill you perfect forms, or get into perfectionism with the form,
144 but actually they report no change in their actual behaviour, or how they actually feel
145 about it, or... You know, they can fill you, fill you up great forms and say, 'Well...

146
147 *So what?*

148
149 ...I suppose that's meant to make the difference.' Yes. Yes, exactly, so what? And I
150 personally can understand that. (laughs) Because I can do it too, and still think, well

151 actually I still think...still struggle with these same issues that I had when I was eighteen
152 years old. In the rational I know I can deal with it day to day, but actually, still I'm
153 worrying about it. So, I suppose it...it's instinct, clinical experience, you know, just
154 giving them that kind of...just experimenting I suppose if you want to put it in those
155 terms. You're offering them something, they try it out, and you see how they manage.
156 Now I would acknowledge, there is some tendency to assume that beforehand. I would
157 wonder the extent to which one might, speaking personally, might just have less of a go at
158 doing things that are, you know, in a more surface way if you like, or a, a thought level
159 for instance, because you...

160

161 *Because you find it more boring, or unconvincing?*

162

163 Maybe. Or you...or just experience tells you that surely this would be better if we go into
164 it at an assumption core belief level, or, you know, we take...

165

166 *And that also assumes it's going to be longer.*

167

168 Oh which...which will, by definition assumes that it's... I would say it seems it's going to
169 be longer. Because I don't think you can stir people up.

170

171 *Are you someone who goes along with what some of the other people say, what's the
172 point of cutting out half the tumour, or, you need to cut out the whole tumour?*

173

174 I... With the patients I work with now, no I...not necessarily, because, that isn't my... I
175 don't think it necessarily means cutting out half the tumour. My instinct feels..

176

177 *And that's what it means, what you're doing is cutting out the whole tumour...*

178

179 Tumour. No I know.

180

181 *Just half isn't going far enough.*

182

183 I know it sounds as if I'm saying it doesn't go far enough, but if it achieves change, and
184 they manage to function day to day, then I, I can see the logic of doing that. So no, I
185 don't by definition believe you have to go for the whole thing. And I actually think you
186 can stir things up and leave people in a worse position, and clearly if you can only work
187 for so, for a slightly bit longer, but not for a really long-term relationship, you certainly
188 can leave them feeling worse about themselves. Whereas if you can give them a few
189 tools which, if you want to in turn...

190

191 *So when do you decide which?*

192

193 [pause] Back to what I...within early sessions, I would say. When I say early, I'm talking
194 about within twenty sessions.

195

196 *Mm.*

197

198 But, then whether they have forty, fifty, sixty, seventy, eighty or whatever, that
199 becomes...that probably varies with patient to patient; probably varies on how I'm feeling;
200 probably varies how systematic I'm being. But fits with my general experience that the
201 patients I see do need much, they need...they need long-term relationships within which to
202 develop any sort of...everything. I mean I think the relationship is fundamental to the
203 therapy. [pause] Which is not to say it's not important in a short-term thing, but it's not
204 so central in that way. Clearly you have to have a good relationship, but if you're...and
205 they're getting on and doing things and they feel...

206

207 *So what makes you decide when to stop?*

208

209 To stop therapy altogether?

210

211 *Mm.*

212

213 Well that's very tricky.

214

215 *Mm.*

216

217 Very tricky indeed. Sometimes it's a case of stopping when we have...we have been
218 working... I suppose, if there's a sense of absolutely no, of getting nowhere, and by that I
219 mean producing no change in their behaviour...

220

221 *Would that be after, say, ten to twenty, or would that be after fifty to sixty?*

222

223 After fifty to sixty, much more likely. Because of this business of knowing there's a high
224 level of ambivalence, we tend to hang in there much longer. But I'm not saying that's
225 always the right thing. If they really want...if they seem to want to come, that seems a, a
226 good indication, although you could argue it's not necessarily. So if they want to come,
227 and they still want to...and they're prepared to work, and they seem to be making
228 progress, however little, then I will see them. My biggest issue is, those people who want
229 to come, but seem to show not a jot of change. And I have real problems there knowing
230 what to do with them. I've had quite a few issues, particularly a patient recently who, the
231 parents have just written to me, you know, and they're absolutely furious, and I've
232 thought, you know, I'm thinking, well she's got...she's not psychologically minded, she
233 hasn't been able to bring about change; she's actually physically OK, and basically she's
234 a chronic patient, and actually I think it's a waste of my time to keep seeing her.

235

236 *And how many did she have?*

237

238 Oh she'd had various stints, because she's had in-patient treatment, but overall she would
239 have...we're probably looking at more than...a hundred sessions remain – overall, in bits.
240 In actual fact, when I first met her, they didn't want to have anything to do with us, and

241 now they do think, you know, great, I'm the saviour, but the truth is, I'm not a saviour.
242 What needs to be done is the changes within the family, and we've tried to work with the
243 family, and it was partly working with the family therapists that gave me almost courage
244 to say, 'Look we've done...we said it within the family work, and we said it within...' and
245 I gave them courage to say in with individual work. And to offer a final admission,
246 which we did, she got her weight much better, and then saying, 'Well follow-up would be
247 best, probably done with OP the dietician to review your diet.' Not... Because when she
248 comes, she hasn't got nothing to say anyway; I mean it's the most awful experience
249 possible, and I do feel then cross that you've wasted your time. But she wants... I'm not
250 sure she wants to come; I think it's her mother wants her to come, and that's the
251 complication you have with lots of these patients, because the parents are so often very
252 involved. But it's interesting, because I'm just finishing with a patient who I've seen for
253 117 sessions, and she happens to be moving...she was a student here and she happens to
254 be moving to F, and she's done really very well, and, she's...she can't bear leaving, and
255 I'm just thinking, well... I think I would have found it really difficult to end with her if
256 she wasn't going to F, even though intellectually I know this is probably the right time for
257 her to move on. But she comes from having worked in private therapy and having been
258 messed around in private therapy. [pause] And I got quite muddled about the extent to
259 which she had actually finished working, or needed to be on her own, or... Her mother
260 had died, and therefore she was clearly, she had made this clear attachment to me, and, I
261 mean she cries. These are our ending sessions, we've got two more, one month's time
262 and another month's time, and, it's just struck me that, if she wasn't actually leaving...
263 That enabled me to finish almost, and thank...thank goodness in many ways, because if
264 she wasn't, I think I'd go so cruel and dreadful. I'm not sure I could have faced actually
265 finishing with her. And that's when you then get into this whole business of, are we here
266 for long-term support? [pause] And, I do think there's a place for long-term support, but
267 who should be best doing it? But in truth, if someone's become very attached to you and
268 wants long-term support, they want you to support them; they don't want someone else
269 to. But then is that a good thing, you know? And there's that whole debate on, on that.
270 Because what we've tried to do with a group, a chronic group, or a group of patients with

271 enduring problems is to swap some of the people who are attached to individuals,
272 particularly to me, to a group, and it's worked for some, they're prepared to do it, but
273 others, they don't want that, they want to come and see an individual.

274

275 *Mm.*

276

277 And they...you may say, 'Well you're not making any progress,' and they say, 'But I'm
278 really really trying, I want to make progress, and I don't want to be told that I'm just
279 a...stuck living with anorexia,' even though they clearly are. And I really struggle with
280 those. Because intellectually I...

281

282 *So by coming to see you, it's means they're in therapy, so that means that they're*
283 *changing, or possibly can do eventually.*

284

285 Yes. Yes.

286

287 *But if they're not seeing you any more, they...*

288

289 How can they possibly change?

290

291 *[inaudible] yes.*

292

293 Well how am I... If I can't do it with you, how am I meant to do it without you? You
294 know, and you're really sending me to...

295

296 *Condemning me to stay as I am.*

297

298 Exactly, condemning me to stay as I am. And you say, well, quite often we get into this
299 thing was, you've got to go off and do these things to show you're motivated, and they
300 say, 'Well I can't do it seeing you, so how do you expect me to suddenly find the

301 resources to do it on my own? This is a nonsense.' And we had this with time out from
302 the day programme, you know, they're not making sufficient progress, they have to take
303 time out, and then, the parents and them will say, 'But I don't want...I can't do it; I'll be
304 worse if I'm not coming.' You see you do get into that sense, having made a decision
305 that, that you will see them long-term, are you saying you'll see them in long-term
306 therapy that brings about change, or are you acknowledging that you'll just see them long
307 term and hang on in there until they feel like changing, or they're ready to change? And...

308

309 *And what about the waiting list?*

310

311 And what about the waiting list?

312

313 *The people that haven't been seen.*

314

315 Seen at all. Yes, it's really, really tricky.

316

317 *Mm.*

318

319 But then if some of these patients then get very ill, and then they, they enter a cycle of
320 hospital, and then if they're in hospital you have to pick them up immediately, because, it
321 doesn't make sense to have someone in twenty-four-hour care and then discharge them to
322 nothing, so you're forced to sort of pick them up from there. So if you can avoid that
323 cycle, you have more control over it. But it does mean people on the waiting list,
324 although our waiting-lists are probably better than most of the, most of the CMHTs'.
325 And we will always pick up people who are urgent. [pause] But yes. It's a lot of luck, a
326 lot of luck and what happens to be...who happens... You know, who happens to be
327 around at the same time almost, you know.

328

329 *Yes. And I was just thinking...*

330

331 And which therapist they're seeing.

332
333 *But, maybe you're more likely to let them wrap you round their little, wind you round*
334 *their little fingers than some other therapists.*

335
336 No, I... Well, yes, I mean that's one way of putting it. Or, another way of putting it is
337 that I'm much more prepared to tolerate the dependency some of these patients show. I
338 can tolerate, it doesn't get me so wound up, and by allowing them to have long-term
339 relationships, and doing work with me, then that keeps them at an even keel; whereas
340 other patients, other people discharge their patients, they go off, and, and I'm not saying
341 they all do, but they might then go into free fall and we have to start the whole thing
342 again. And I, and I...I am more able to tolerate those kind of patients, definitely.

343
344 *And you say you found it more, find it more satisfying to see long-term people than short-*
345 *term people.*

346
347 I don't see anybody short term. But, as compared to short... Yes, because I, I enjoy...I
348 like the long-term relationships, and I...well because I recognise that this patient group...
349 I mean I'd like to do a bit of short-term work as well, it is a balance.

350
351 *What do you call long and short?*

352
353 I'm talking about short, I'm talking about less than twenty, type of thing.

354
355 *So over twenty is long term?*

356
357 [pause]

358
359 *Medium term.*

360

361 Mm, medium term isn't it. I mean often I'd see my patient for, a hundred sessions.

362

363 *Well, 227 is long term.*

364

365 Well that was my...that was the one I pointed out whom I have seen longer than anybody
366 else. Now it's interesting, because, thinking of S1, who I've seen continuously for those
367 sessions, over a long time, I've just been re-referred another patient who I saw about the
368 same...I saw before S1, and I realise that this is the third instance of treatment she's had
369 with me, but the difference with her is that in between, she's been discharged, and she
370 goes off and does her own thing, and I was trying to think what made the difference
371 between finishing with her, the fact that I actually finished with her and then she has
372 come back, but... And S1 who I never finished with. And it seemed to be, partly the
373 difference between the two was that, A had a lot more resources out in the community,
374 she had much more of a sense of, that she came to see me to do specific work, and if she
375 wasn't ready to go further, it was quite easy for us to agree that she'd got as far as she
376 could get, and she could...she would now go away. And I made it clear that she could
377 always come back to me. And in many ways, that's...that's quite ideal, if people can do
378 that.

379

380 *Yes.*

381

382 But she had sufficient resources to support herself. She's very involved with the Church.
383 She got...she got...she finished her degree, which was the first hurdle, so she went off, did
384 that. Then she came back. And she was still low in weight. Then she came back a bit
385 later, and then said she wanted to do some more work and increase her weight. So she
386 came back and we did, we went as far as she could go. But it seemed to be quite clear for
387 both of us at the beginning that she would reach a certain weight and then, that would be
388 it. And the reason she's come back this time is because, unfortunately her mother has
389 died, which precipitated a crisis, and... And she eats the same so her weight's remained
390 the same, which, she's apparently anorexic still, but just at top end of the range, but she

391 eats...her timings are ridiculous. I mean she eats her lunch at six o'clock in the evening,
392 and her dinner at 3.30 in the morning and things. So she's come back to deal with that
393 specifically, to try and help her let go of that pattern. So therefore, again I had this sense
394 that we – and each time it's about twenty sessions – will have that very specific goal, and
395 so we can assess how well we've done with that. And somehow if we haven't managed
396 it, we'll assess that we've given it a good go. And it's very striking that it feels quite
397 straightforward and clear and... And she's always kept in contact with me, but... So, she
398 hasn't become so dependent in some way. So I don't quite know how, how that's worked
399 out. But I've known her longer than I've known S1. She had a good family, family, yes,
400 and that has, that's also been... Where S1 never had any, any kind of backup whatsoever.
401 [pause] Similarly...

402

403 *But with S1, just to summarise it very quickly...*

404

405 Mm, yes.

406

407 *You gave her that many sessions over a very long time, because it actually, you reckoned*
408 *it saved a lot of money and time by keeping her alive.*

409

410 Definitely.

411

412 *Keeping her out of hospital.*

413

414 Definitely. And you can actually look at the extent to which she went...

415

416 *Keeping her supported at times as well as change type stuff.*

417

418 Yes. Yes. Yes.

419

420 *And that it was cost-effective in the long run.*

421
422 I would argue that definitely with her. And similarly with patient J, who in fact I took
423 over from, someone we were referring to earlier.
424
425 *Oh yes, yes yes yes.*
426
427 And, the thing is with J, she's now doing her Ph.D. at University, I mean that's amazing
428 compared to what she was doing, but she requires enormous input. And she, she rings me
429 at home, she looked me up in the phone book. But to be fair, she never rings for more
430 than five minutes. And I've made it clear to her that... And you know, so she's someone
431 who...she seeks that kind of reassurance, but she is easy to reassure. And we've tried
432 endlessly to try and set her on her way, on her own; she can't manage it, and she then
433 becomes very acutely ill, and the last time she was in hospital for one year. So, me seeing
434 her once a week and taking...phoning her, and, she'll come and see other people,
435 members of the team, she...it's definitely cost-effective. And we keep a good relationship
436 with her, we tolerate it, whereas it's freaked everybody out in the past, and you know,
437 she's... We have had little crises. It was her fortieth birthday and she wanted me to go to
438 her birthday party, and that was...I explained to her I wouldn't do that. She wants me to
439 go to her graduation when she gets her Ph.D., and I've told her I will do that; if she
440 graduates for her Ph.D., I will... Because that, that feels like that will be possible to do,
441 whereas the birthday...
442
443 *Less personal.*
444
445 Exactly, less personal. And so I was able to be clear that...that I could do that, and that
446 was OK, but I wouldn't come to the party, that wasn't OK. Although it was quite
447 difficult for her to see that, because she sort of sees us... She has got a mother and a
448 sister, but her mother's part of the whole issue, because her mother has been terribly
449 disturbed throughout her life. But she...she would drive other people mad. You either
450 love J or you hate her, but if you can...she's...she's a scream. She's the one who set up

451 bed in my office overnight when we left. Of course, that would happen. But... But it's...
452 For instance, it's interesting, because that basket of red flowers there, they came from J at
453 Christmas. Now that, in all the time I've known her, that's the first time J's actually, we
454 managed to get to the point where she could think sufficiently about someone else in
455 order to actually give them a present. Which, you know, most of the others would do
456 without thinking, but J is so self-centred. So I thought.... And she bought a box of
457 chocolates for the rest of the staff. And that was real progress, because she could...she
458 says, 'I know it must take a lot of effort dealing with me et cetera.' Well, she's never
459 been able to notice that before. And she is doing this Ph.D., and she luckily has got this
460 crazy supervisor who sounds quite as crazy as J. So if we just keep her weight up
461 sufficiently. But she'll always need you to be there, literally. But, that's OK. I think that
462 is OK. So is that support or continuing therapy? Well, I suppose it's support, but it has
463 enabled her to continue to make changes. I mean I would say her being able to think, it
464 would be nice to give a present, was a tremendous change, as compared to how she used
465 to be. [pause] And how would we have known that from the beginning? Well what...the
466 person who saw her before did try and end therapy with her, and we've learnt it from her,
467 with J, that actually experimenting with a kind of sense that, you can't go on seeing
468 someone like this, let's try and reduce the relationship, and then you see what happens.
469 And I think, well I've concluded that she can't do without that kind of... And she needs it
470 from one or two people. What we've managed to do over the years is get more...we've
471 got her to live in a group home for instance, which has a better backup system, but she
472 still needs a named, one or two people who are her family.

473

474 *Mm.*

475

476 You know, and you can say, we shouldn't work like that, it doesn't help you, whatever,
477 but for J it means that she is functioning miles better, and is not in an in-patient, in
478 hospital for another, you know, year or so. So, you can justify it on that basis.

479

480 *So are there ever pressures from other systems? You say families to keep people going,*
481 *you go on seeing people, or to take people on that may be....*

482
483 Families in the CMHTs will always prefer you to keep them. Community mental health
484 teams definitely don't want them to come back. There's very much a pressure to keep
485 our, all our patients. And when we try and... For instance when we've tried to look more
486 generally at the idea of, some of these patients have just as severe long-term needs as, say,
487 people with schizophrenia, there's great resistance to see them in that way. And there's
488 always the sense that, you're the experts, you know them, you keep them. Which is why
489 they wouldn't object, they wouldn't object to us keeping them long-term, because they
490 just, they see it as, that's what we should do. Families definitely like you to say it, you
491 know.

492
493 *Is that a difficulty for you sometimes?*

494
495 Yes... It is, in that they also want us to take urgent cases immediately. Yes. And to try
496 and get them to look at these two things alongside one another, they're not interested,
497 because everybody's under such pressure all the time.

498
499 *Yes, of course.*

500
501 *You're expected to....*

502
503 *And GPs, do they put pressure on?*

504
505 They vary. They vary. We've got some very good relationships with some GPs. And
506 because we don't have a medic in our team, some of these long-term patients are
507 maintain...the medical side is maintained by the GP, and they like that, they like to have
508 the back-up. But some just like to hand them over, and expect you to do miracles,
509 complete miracles.

510

511 *Of course.*

512

513 But others are pretty good, and we have got particular ones who we know are pretty good,
514 and just like coming out and have a chat and then that makes them feel they can contain
515 their patient. So that feels then like working well. [pause] I think they feel then, if they
516 can have access just to check something out with you, or if you stop seeing that person,
517 you re-see them, that, that... Maybe that's part of the thing with A, that her GP was, has
518 always been involved and is OK about being involved. You know, I offered her..., the
519 GP was the mainstay support.

520

521 *Yes, that they could take over that role.*

522

523 Yes. Yes.

524

525 *You could share it.*

526

527 Yes. Yes.

528

529 *So are there pressures to stop seeing people?*

530

531 The wait list is the obvious one, definitely.

532

533 *Mm.*

534

535 And we have recently looked at, people who do outpatient work, look at our percentage
536 of face-to-face contacts et cetera, because of the wait lists, and, I mean my face-to-face
537 contact time is about sixty per cent.

538

539 *God!*

540

541 I mean it... And...

542

543 *That is terrible.*

544

545 So, I think it's...it's sixty per cent of the time I'm meant to work, I think effectively it
546 means I work more. Q's is about fifty, but P interestingly keeps much more to, I think
547 hers is about thirty-eight. And the irony is that as far as I can understand, it should be the
548 more senior people who're having less face-to-face contact. But then I like seeing
549 patients. So, you know, it's a kind of...

550

551 *But, what also seems to happen in your team, that there are other people to take the slack*
552 *if you like, to take the short-term people, so maybe have greater throughputs, which*
553 *allows you to have them for longer then.*

554

555 Well...

556

557 *Is there a balance there do you think?*

558

559 [pause] I see. [responding to surroundings] [pause] No, theoretically we're all meant to
560 take the same.

561

562 *But in practice?*

563

564 In practice I give the simpler cases to the less... Q...I...I do all the, the referrals, and I
565 keep... All urgent referrals Q and I do. The most urgent ones I do simply because I've
566 got the referral so therefore I can do it urgently more easily. So yes, the less experienced
567 people definitely get the more simple cases. And assessments, you know, I...we do a lot
568 of the assessments. And that's part of the face-to-face contacts, you know, it's a large
569 number, of doing the assessments, and we always do the assessments within... Urgent

570 ones we'll do within a week, and less urgent we'll do, definitely within two to three
571 weeks, which, that's the way we kind of, work it. [pause] Because you have to respond
572 to the urgent...the urgent patients are really urgent, might even die on you. Mostly they
573 are urgent actually, and that's the thing that's possibly different to some of the CMHTs.

574

575 *Yes, and urgent in the death kind of sense.*

576

577 Yes. Yes, there are some you overreact to, but for the most part they are really urgent.

578

579 *What can we do to keep them alive?*

580

581 It's more a case of, going in there and saying, 'Actually, these are the tests you need to
582 do; this is not...this is serious.' Or, 'Take this person to the general hospital.'

583 It's...it's...they want decisive action, because people are still terribly unsure.

584

585 *You mean people like GPs or the team?*

586

587 Definitely. Definitely. And it's the students, this is why we have such a bad term this
588 term, if the new students who pitch up, and... This student I've just...she...you know, she
589 was BMI of ten, which is ridiculous. And the university had taken her, GH is her GP so
590 she had, immediately referred her to us and said, you know, 'She does not see this as a
591 problem,' and it turned out they were identical twins, they've never had periods, they've
592 always been low in weight, and over the years the mum and dad have said, 'Well, people
593 have just said, given them the Pill to make them have periods,' rather than, you know,
594 saying, 'This is frank anorexia.' So although the daughter was terribly resistant to what
595 we had to say, what I had...we, no, there was GH as well, and then IJ's taking them on,
596 taken over, because GH's on maternity leave, the parents were relieved. And when...the
597 father, I spoke to the father the other day, because we've...she's...we've asked her not to
598 return to college, he was saying, 'But round here the GPs said, why have we come?' And
599 it turned out they hadn't got our fax letters. But the point was still weighing this girl with

600 this low weight, with no history of periods or anything, they were more or less saying,
601 well...

602

603 *What's the problem?*

604

605 What's the problem? And their parents were saying, 'We feel now that after having got
606 recognition that there is a problem, in E, we now feel we're back home again, and we're
607 concerned we won't get the treatment we need.' Well I have rung up everybody and
608 faxed them fifty times now, so hopefully they will do something. But quite often they
609 need someone to say, 'Actually, this is not good news, this is really bad news.' I think
610 there's a lot of...people like you to be decisive, like you to have a definite view. I never
611 cease to be amazed by, I don't know whether this is completely off the subject, by the
612 extent to which individuals call you to give an expert opinion, and you have to say
613 something I think is pretty ordinary, and they're so relieved that you've sort of made the
614 judgement here, or said this is not possible. Often it's in relation to what's feasible in
615 terms of long-term treatments, and it's actually quite often saying, 'There is no point in
616 kidding yourself, by holding this person in hospital you're suddenly going to change their
617 life around.' Or treating them against their will.

618

619 *Hospital meaning a physical hospital?*

620

621 Often it arises from physical hospital, but then they want to transfer to long-term
622 psychiatric input, specialist units, when they've had so many admissions already, they've
623 made it quite clear they're not going to do anything more. And actually, I've had recently
624 two much older people, a sixty-eight-year-old and an eighty-year-old, and I just was, you
625 know, come on, get them to what...what's physically viable, put as much support in as
626 possible. But to sort of, against their will, fight them, in hospital, when it's driving every
627 single nurse bonkers, don't do it, it's not worth it. And they say, 'Right, now you've said
628 that, they'll act on it.' But they won't take that risk themselves, not surprisingly. So it's
629 with the elderly, with the elderly, it was KL, what's his name?

630
631 *KL.*
632
633 KL, yes. And I thought, well, surely this is pretty obvious. But actually they wanted... I
634 think it's been seen to be doing things correctly in that way, they want you to give the
635 expert opinion, 'No you do not have to keep sending the nurses in the general hospital
636 completely bonkers by keeping this woman here'. (laughs) She was great actually. Of
637 course I came in, chatted to her, and just had a great chat with her for an hour and a half
638 about her life, and her going, 'These nurses, they're trying to make me do this, that and
639 the other,' and... Well it's mad. [pause]
640
641 *So, are there things, are there things that keep you sort of focused, like, or keep you*
642 *going, or, help you stop? You've mentioned helping you stop. Like, supervision or line*
643 *management?*
644
645 I've never found line management affects what I'm doing. (laughs) But, Q would
646 disagree with you totally. It's interesting because, we were discussing this business of,
647 you know, appraisals, and she puts such a store on appraisals and how, what a
648 fundamental change it's made to her whole career development and life et cetera, and I
649 just thought, well, well maybe...
650
651 *No effect whatsoever.*
652
653 Well, I found it quite extraordinary.
654
655 *Very rarely happens anyway.*
656
657 Well, but... Yes, that's how it struck me. Because she was saying, 'We must get O to
658 appraise this before he, you know, he moves on.' Well I said, 'Well fine, but, I don't
659 know what you expect to happen out of that.' I mean... Supervision. I think I said

660 before, we have peer supervision, Q and I, and I do think that that will influence how I
661 think about something. And because we, we...because she's so obsessively keeps to the
662 rules, and I much more spontaneously do whatever I think's right, I think the kind of, the
663 partnership does work very well, so definitely I would say that was an influence. So
664 therefore I would say, I am influenced by people whose judgements I would value; I've
665 known over time that they...

666

667 *So that might influence you into keeping things shorter, or...?*

668

669 It would, yes.

670

671 *Focusing.*

672

673 It would, but it would mostly be people that...I think...it probably only... [pause] Q
674 particularly comes in with that experience, because I know she works...because she works
675 with the same group of patients, although...and I know she comes from a different place,
676 so I would hear and think about that. I've had some meetings with, N's in my supervision
677 group, and we meet, and she's said some things that again, some more senior experienced
678 person has, you know, made you stop and think, definitely. But mostly they say it's fine
679 what you're doing. (laughs)

680

681 *Do they sometimes say, 'Keep going'?*

682

683 Yes, they do. I never forget the experience when I took G, who still writes to me... In
684 fact, that's a good example, because I originally took her to my supervision group when Y
685 was in it. (laughs) Personalised, this is meant to be. But, I was assuming Y would
686 immediately say, 'God! you can't go on seeing this person, this is ridiculous.' And...he
687 didn't. He said, 'No, clearly you need to go on seeing this person, because you're...she's
688 made a very strong relationship with you, and you can't just dump her.' Well I was
689 completely stunned. And interestingly, recently I brought it back as a problem to N,

690 because she still writes to me, emails me, and she was totally clear that, 'Don't be
 691 ridiculous, you've got to...' Because what happened was, she...she left E, went back to
 692 home in G, without a proper ending, so we always had a sense that we would try and have
 693 an ending, but she became completely phobic about travelling, so therefore never got to
 694 have this proper ending, so therefore continued the relationship by writing or phoning.
 695 And it's gone on for years, and it is ridiculous. But N was completely clear, 'Right, OK,
 696 you acknowledge what's happened, you write your final goodbye letter, and it ends,
 697 there's no question of allowing this to...' And I thought, oh, that's interesting. And
 698 actually I found that quite helpful, because it almost gave me permission to be...

699

700 *And did you then do it?*

701

702 No, but I have been much stricter about making it clear that she must engage with her
 703 new therapist.

704

705 *Oh, right.*

706

707 And she has to think about... Whereas before, I just kind of replied, or picked it up. And
 708 what had happened was, she actually ran away from home and pitched up in E. Luckily I
 709 never saw her, she didn't tell her parents where...where she was or anything, it was awful,
 710 and I thought, no, this is crazy, I've got to stop this. But then discussing it with N who
 711 then said, 'This is crazy, you've got to stop this,' actually helped me, definitely, so I was
 712 definitely influenced by what she had to say. But you could argue, I was influenced
 713 because I was already feeling that, and I just needed someone else to definitely say....
 714 So... Yes, so it's colleagues whose opinions I will value. I would definitely...

715

716 *Not...not less experienced people?*

717

718 [pause] No, I wouldn't say definitely not, but I don't tend to...I don't tend to be exposed
 719 to.

720

721 *I mean, we've got a third-year in our peer supervision group.*

722

723 Yes, but our supervision group doesn't work at all.

724

725 *And she can be really really useful.*

726

727 Yes. That, I do not have any problem with that idea at all, it just doesn't happen
728 generally. So I don't have any, any problem with that. I mean that's, N is the only one I
729 ever meet with in our supervision group. M for a while, but... [pause] No, so I, you
730 know, I'm... I'm actually happy to hear what anybody has to say in that way.

731

732 *Mm.*

733

734 Hopefully let it...I will try and think about it and let it influence. And clearly the newly-
735 qualified people are much more up-to-date on some of the research et cetera, or... In
736 general terms, not in eating disorders. I do carry prejudices and things about. Like we,
737 we have a regular meeting with MN's team, and I suppose I'm continuously disappointed
738 about what they have to offer, because they don't have enough experience of the patient
739 group. It's quite a rarefied experience.

740

741 *Because they see the easy side of eating disorders?*

742

743 Mm, well, it's certainly more straightforward.

744

745 *Mm. Yes, I don't think they're the real world.*

746

747 I don't think they are too. And it, you know, people continuously say, 'Oh MN he's
748 expert in anorexics,' but he doesn't know enough about it, he really doesn't. And actually

749 I think he's quite sensitive to criticism and stuff, so he won't put forward his ideas, and
750 this is quite extraordinary in the group.....

751

752 ...Other influences. What else might I be thinking of? [pause]

753

754 *Supervision, line management, colleagues, other professionals. In the team. Like in*
755 *different kinds of teams, CPNs can put pressure on, but you don't have that sort of set-up.*

756

757 No. [pause] Oh, I think one of the issues in our team is that, if people can't take the
758 pressure, then we just...I just take it off, and I take it off more than anybody else, because
759 I...because they just...they can't...and we just acknowledge that different people can bear
760 different amounts. And that is an ongoing issue. And sometimes, it's just a case of
761 recognising it. What I think they should be more place for is to actually stop, have
762 sufficient time to actually enable them to do it more. I do think that, that, that...a
763 difficulty of all this is that you end up, you do things because it's faster to do it, but
764 actually then that keeps it...

765

766 *Not changing.*

767

768 Not changing. I think that keeps too much of the expertise in...on experience, in one
769 place. And I talk with P about it, for instance, and she...she was saying, 'Well, don't you
770 think I'd be capable of doing that?' or... Or, 'You're right, I'm probably not capable of
771 doing it, but couldn't I come out and do that with you and then that would enable me to
772 take it on?' And that is true, but of course that takes more time. But I do think that's
773 what needs to happen more. Which is why we've tried to instigate, we had a meeting,
774 which was why we tried to instigate, the four of us who see outpatients regularly, meeting
775 more and reviewing every... What we decided was that we would review every ten
776 sessions I think whether they should go on to the next ten sessions, you know, to actually
777 do it in quite a conscious way.

778

779 *And open way.*

780

781 And open way, yes. Yes. Yes. So hopefully then that will, we'll influence each other
782 more, because a big discussion we had beforehand was that it would be totally pointless,
783 if people felt defensive or they felt like from the beginning they were going to take no
784 notice.

785

786 *So, what we haven't sort of talked about is, to what extent other people know what it is*
787 *you're doing, and that you're seeing some of these people for such a long time, do you*
788 *keep it...I mean is it just by default, is it not known, or do you actively keep it a secret, or*
789 *is it...*

790

791 Oh no.

792

793 *...or is it open and known, or...?*

794

795 No, I think it's pretty known. There's no need to...nobody would question, nobody would
796 actively question, I think that's the point, probably a matter of power as much as
797 anything.

798

799 *Do you feel guilty about it ever?*

800

801 [pause] No, because I actually feel... I don't feel I see people for just...for the wrong
802 reasons. I really do feel that I need, they need to be seen. I think about it, and sometimes
803 I wonder, but I actually don't ever feel guilty about it. Because also I know I see plenty of
804 others too. If I only had a few long-term patients and that prevented me seeing urgent
805 cases or doing things et cetera, but maybe that's part of the reason I then go into overkill
806 and see all the additional people, is, you could argue, I don't know, is, to make up for... I
807 don't know. I don't feel guilty about it. I make other people feel guilty, and I can see
808 they don't like that, and that's unfair.

809

810 *That they should be seeing more long-term people?*

811

812 They should be just seeing more people. (laughs) Doing more work. It's funny, because

813 Q and I were laughing. We're the two part-time people; she goes home, she does lots of

814 work at home; the difference is, I stay at work. And everybody else is full-time, and I'm

815 in there in the evening, I say, 'I'm the bloody part-time worker, why is there not another

816 soul in this building?'

817

818 *P's part-time isn't she?*

819

820 Yes, she's...she's five sessions, but she's...she does whole days, she does two whole days.

821 P doesn't stay beyond five o'clock for the most part, ever. People don't. They cut off our

822 lines at six o'clock, we have to go through switchboard. It's because of what it used to

823 be. Stop patients using the phone. [pause] So, anything else?

824

825 *Anything that you see differently now, from how you saw it before, as a result of talking?*

826

827 [pause] I think that, it's interesting, since we did our oriG1 interview, we have put into

828 practice this...you know, the meeting to review the thing, and we really have... And...and

829 I think, particularly it's given more junior members of the team the possibility of having

830 more joint discussion about how long a time we see people or not. [pause] I think it just

831 makes you stay aware all the time. And very much, I was very much aware of it as I say

832 with this S2, who, you know, the one who's moving to F, and that enabled me to...

833

834 *S2?*

835

836 Mm, she's called S2. [pause] And, I think S1, who is the one whose parents got cross et

837 cetera, and I said, 'I'm not going to continue this thing.' I mean I've...these things are all

838 happening and, you know, you just become more focused on, what can I do or can't I do.

839

840 *And in actual fact we're changing all the time ourselves, aren't we?*

841

842 I think so, yes, definitely. Well, definitely. Definitely. Well I am.

843

844 *Because what I have been aware of in this interview, that, whereas in the first one we did*
845 *talk more about when you were in the central service.*

846

847 Yes.

848

849 *And being much more focused on eating disorders this time.*

850

851 Yes.

852

853 *But it's also that, the way **you** view things has changed, and I'm sure I would say the*
854 *same about myself, I'm changing all the time, how I do my work, and within the system*
855 *and so on.*

856

857 Mm. So is this going to make it very complicated, the research you're doing? (laughs)

858

859 *Yes, ruined, ruined it completely.*

860

861 (laughter)

862

863 Oh dear!

864

865 *Shall I stop it there?*

866

867 Yes.

868

869 [End of Interview]

1 *So I'd like to ask you why you've offered one or more patients twenty-six or more*
2 *sessions of therapy, and, it may help you to think about specific people, but it's your*
3 *decisions that I'm interested in.*

4
5 Three of the people, the people who seem to have really engaged in cognitive therapy and
6 be using it themselves, and seem to grasp the model, show some signs of progress, but
7 then have setbacks during therapy really, a feeling that they're not at a stage where it
8 would be appropriate to discharge them. I think with those people I have also...they have
9 been people with low self-esteem, as well as the presenting problems and these have
10 tended to [inaudible], things have tended to shift, anxiety, depression.

11
12 *Shifting problems.*

13
14 Shifting problems through treatment. And these people are having to work, done more
15 work on assumptions and beliefs as well as the Axis I issues, if you like.

16
17 *So at what stage did you decide to carry on?*

18
19 I think...I think with all the people I had sort of, ten sessions in mind to start with, but
20 then when the ten session sort of limit came up they were still with the shifting problems,
21 and there still seemed quite a lot to work with, more you could do I really felt they could
22 benefit, and I was hoping that they'd get better.

23
24 *So it wasn't about maintaining them, it was about continuing progress.*

25
26 Yes, continuing treatment really, yes, definitely. I think if they had been feeling better
27 then I would have found it easier to discharge them into follow up, but they still had
28 ongoing problems that they were struggling with that made it hard to finish sessions. I
29 think with all those people I did sort of take it five sessions at a time, but just kept going.
30 (laughs).

31
32 *So at each of those points, five-session points, were you doing a review in your head, or a*
33 *review with the patient, or with your supervisor, or...?*

34
35 A review with the patient, and when I was discussing people in supervision, and the
36 supervisor was aware of how long it was going on, and was the line manager. I don't
37 know if I was actually spelling out...

38
39 *The supervisor was your line manager?*

40
41 Yes.

42
43 *You don't know whether you were spelling it out?*

44
45 Exactly how many sessions. (laughs) But the fact that, you know, they did, there was
46 somebody else discussing it, these things, and had a rough idea, of sessions.

47
48 *So that sounds a bit as though you were embarrassed about the number of sessions, not*
49 *wanting to be quite open about it.*

50
51 I think when I go over twenty I start thinking, is this OK? What would other people
52 think? I think there's a mixture of feelings. I think my line manager thought there were
53 exceptions where it was OK. I felt reasonably OK. I think it's more difficult to admit to.

54
55 *So do you think that's partly a function of being relatively newly qualified?*

56
57 That I worried about it?

58
59 *Yes, that you were worrying in this way, what do other people think and...*

60

I think it's more this expectation that we can only offer very short-term treatment given the waiting list we have, and, [pause], breaking the rules in some way. I think it's like I'm still struggling with those issues really. When you see somebody for thirty sessions, it does have a look of... It's quite difficult.

And so when did you...how did you come to decide you were doing five sessions and review, that you were going to finish?

[pause] Mm, that's interesting. I think when the people concerned were moving towards recovery, and their scores on questionnaires were lower, so, sort of mildly depressed or mildly anxious rather than moderately, and questionnaire scores were, or the Beck scales were sort of approaching ten. And I think also, which, it was when they, they were also feeling more able to cope without the sessions, and... Because I think seeing people for that many sessions gives a danger of dependency. And think, I think with probably all these people, they feel quite anxious about ending the sessions and sort of working on things independently; I think it was at the stage where they were feeling a bit better and feeling ready to do that, I then found it easier to say then, this is the right time to go into follow-up.

So you're the one that made the decision.

Well, I think it sort of, you know, it was discussed, and I think it was at the stage where they, you know, were feeling a bit more comfortable with the idea. I'd been preparing them for the end of the sessions, but... And I probably was responding to their anxiety between the sessions. But also taking account of the symptoms the symptoms they had presented with, how distressed they were [inaudible].

Any pressures on you to continue or to stop?

90 [pause] Not... Not really. I mean I guess just know that I didn't want it to, to keep going
91 on and on, pressures of having a waiting list really, but...

92
93 *Because some of the people have mentioned pressures coming from the team, or from the*
94 *GP. Sometimes to go on seeing somebody.*

95
96 Mm.

97
98 *As well as to stop, of course, like line managers.*

99
100 With all of these people actually getting clear messages from the team and GPs.

101
102 *So what sort of problems do the patients have?*

103
104 Shall I go through them all? (laughs)

105
106 *Yes, yes.*

107
108 One person presented initially with panic and social anxiety, but he also had very low
109 self-esteem, and once we'd made some progress with the social anxiety he became very
110 severely depressed. Another was, she presented initially with severe depression, but was
111 also quite socially anxious. Another person was quite severely agoraphobic and
112 depressed. And there were, there were, there were some self-esteem issues, but there
113 were quite specific ones rather than general problems in certain areas, and sort of working
114 with one belief. The other person, somebody with...

115
116 *The fourth one?*

117

The fourth one. Somebody with longstanding vomit phobia, which had led to, well actually she had anorexia as well, a continuation of problems and low mood and self-esteem.

Would you describe them as having personality disorders?

[long pause] It's really difficult. I don't think they'd meet diagnostic criteria for personality disorders D.S.M. IV. I think they all had longstanding self-esteem issues, and had problems like, ever since childhood they'd had problems with anxiety or depression. But I don't think they necessarily fit in to those categories. And I think, I mean, only one of the people has a significant inter-personal problems. The other people were fairly good at making relationships and things like that actually, which probably meant they were then more able to make use of therapy, I guess.

Have you worked with personality disordered people?

Yes. (laughs)

And, have you done longer therapies with them? Are they the twenty session type people, not as much as twenty-six?

I guess the people who come to mind are people who've had really very significant interpersonal difficulties, and very severe problems who haven't been able to sort of engage in and make use of therapy. The one that immediately comes to mind.... And there was somebody I saw recently who had personality issues who made very good use of ten sessions, and use of self-help material and I had wondered at the start, you know, is this somebody who's going to use a lot of input to get to things, and she made very good use of it, and I hadn't thought she would. So I think it's really difficult to predict how it's going to go.

148 *Yes. You haven't said much about the fourth person.*

149

150 Have I not?

151

152 *No.*

153

154 No, I guess she's a little bit different to the others. She didn't actually engage fully in sort
155 of cognitive therapy and there were social issues, that seemed to be more important, that
156 seemed to be undermining what she was trying to do. I think I stayed involved with her
157 for more than twenty-six sessions, because, she was making some progress. I'm not
158 really sure what that was down to, whether it was the support and encouragement of
159 actually engaging in cognitive therapy. And I think because she was very low weight it
160 was very difficult to pull out, because of the risks of deteriorating, and she was very
161 anxious about that as well, so that's why we sort of continued, and she's made steady
162 progress.

163

164 *And so she was anorexic, was she?*

165

166 Yes. Yes. anorexic and vomit phobic.

167

168 *So with her it was slightly different, in that you were...you were worried about her, you*
169 *felt that you had to stay in touch with her and keep going with her, and that element of it*
170 *might...?*

171

172 Yes, it was a bit different in some ways, it was...yes, I was worried about her being, about
173 her low weight. I guess a similarity would be between the four of them would be the
174 client's anxiety about ending therapy, I guess. And she was really anxious about losing
175 weight.

176

177 *So how did you come to finish with her?*

178
179 Well it got easier as she put on weight. And then, we had, we had regular reviews, and at
180 the last review we considered the options, which were, either her taking bigger steps
181 really and do more challenging, with behavioural experiments, or her being supported by
182 a practice nurse, for sort of ongoing support, not from me. And she decided that she
183 wanted ongoing support rather than to work more in a cognitive therapy-type way. That
184 was easy, because she was very different from the beginning. So she decided, chose that.

185
186 *Well, she decided, and you decided as well, but with the others ones it was a bit more*
187 *you, than them... Or was it the relationship between you? Do you think there's*
188 *something about people that hooks you in, or...?*

189
190 Yes, I think...

191
192 *Or even makes you collude with them...*

193
194 I don't know, because, I think this is saying something about finding it difficult to
195 discharge people who are anxious about being discharged, but on the other hand, you
196 know, they did have...I discharged them at a point where they had sort of improved quite
197 a bit. In other ways it might seem appropriate to because they are feeling less distressed
198 and have reached a stage where from moderately depressed or moderately anxious, things
199 were going well. So, it could go either way, I think. (laughs)

200
201 *Well I suppose sometimes it might be easier to keep going with somebody because you*
202 *like them, or keep going because you dislike them slightly but feel guilty or feel you ought*
203 *to, or...*

204
205 Mm.

206
207 *...something like that.*

208

209 Yes, I can, I can see that. And I guess if somebody does engage well with cognitive
210 therapy, it's easy to run with them. So you might say to yourself, well they're more likely
211 to get something out of it, because they're engaged but I guess also it would be more of a
212 pleasure to work with them and be their therapist and to continue.

213

214 *Yes, I think I do prefer those sorts of people really. (both laugh)*

215

216 I feel a bit, it's a bit difficult to admit that I continue longer with people just because I like
217 them, but I'm sure there must be something in that, if I'm honest.

218

219 *So what part do you think might have been played by supervision or line management in*
220 *deciding to carry on or to stop or whatever?*

221

222 Well, not being challenged about it. (laughs)

223

224 *So a sort of, negative way?*

225

226 Yes. In the absence of somebody saying, you know, what about discharging this person, I
227 think I'm more likely to carry on. And I guess, my supervisor, or particular supervisors
228 would be more likely to say that person's hasn't changed, and that person's not engaging
229 and....

230

231 *To say to stop?*

232

233 Yes. They don't seem to be getting anywhere, and asking why continue?

234

235 *Did the supervisor say that about some people?*

236

Not about three of them, but, the fourth person with vomit phobia and anorexia, I think in supervision we discussed does it need to be me supporting this person or can it be someone else and that influenced the discharge in the end. And also thinking about setting more challenging behavioural experiments and things like that, sort of contributed to that decision-making process as well.

It sounds very much as though you keep quite focused because you are reviewing quite frequently, and then you don't drift along into a longer therapy.

No. I think that helps. But I guess it can still be a bit of denial about ending and things. Some people when you have a review, it really does feel like you are deciding whether to continue or not, with other people, I think there's a sort of assumption, 'you're going to continue but let's just check it out and think about it.

What's the difference then, between those types of people?

I think it would be really whether...whether they seem to be engaged in therapy and it makes sense to them. It might depend slightly on levels of distress, if they're very distressed, it might be difficult to contract an ending. But I have recently decided to end with somebody who is very, very distressed, her model was completely different, so we decided that there was not point in continuing at this stage. But that is quite difficult, because she was very severely depressed. It was only after about six or seven sessions.

And maybe it's, maybe it's because they're not so much personality disorder patients, because I know that there are patients where I have no focus really, and I just drift on and on and on. Or they bring new things, and you can never, can't actually finish, kind of thing.

That can be difficult too... Yes, I mean, the people I've talked about haven't really been like that.

267
268 *No, no.*
269
270 I think they, those sorts of people are difficult to work with, and I probably would run on
271 for a few more sessions because of that but I probably wouldn't actually gone on to
272 twenty-six sessions.
273
274 *[inaudible]*.
275
276 *[inaudible]* for five or something.
277
278 *Yes. And where I've waited for sixty sessions or ninety sessions, I still feel we haven't*
279 *started yet. (both laugh)*
280
281 *Mm.*
282
283 *But their problems are so awful that you can't stop seeing them, or there's something that*
284 *keeps you going. But it sounds as though your patients weren't like that.*
285
286 *[pause]* Yes, I guess I might not come across people like that so much, but...
287
288 *Do you think your case load has changed over the years?*
289
290 Yes, I'm seeing more complex people. *[pause]*
291
292 *Anything else you want to add? [pause] Because it seems as though we have covered*
293 *everything more or less.*
294
295 *Mm. I think so, [inaudible].*
296

297 *So, how's it been, talking to me?*

298

299 Fine, yes.

300

301 *OK.*

302

303 I hadn't really sort of thought about it much before, so, I'm sort of thinking on my feet.

304

305 *That's OK. Is there anything you would view differently now?*

306

307 [pause] I'm not sure, but I think I'll think about the issue of whether I'm responding to
308 the client's anxiety about ending, or whether it is reasonable though distressing. I think I
309 might think about that a bit more when I'm coming to the end of therapy with people.

310

311 *OK, thank you.*

1 *OK, so what I want to know is really about the sort of decisions that you made when you*
2 *offered twenty-six or more sessions.*

3
4 Mhm.

5
6 *So, and what point in therapy did you decide to offer that many?*

7
8 I have a sense it's sometimes dictated by...it's probably quite early, rather ironically.

9
10 *At the beginning, or near the beginning?*

11
12 Probably after five or six sessions. I would say that's kind of implicit rather than explicit.

13
14 *To yourself?*

15
16 Yes. (laughs) Well the kind of people that I've taken on have either been people who
17 have been hospitalised, and therefore who have kind of had some sort of severity kind of
18 cachet kind of... And... Or, I think the most recent person I think I offered about fourteen
19 sessions, and during about three sessions before the time up, he made a real big change in
20 his, his work, and I took him to supervision, and actually the group felt that it was quite
21 wrong then to not offer him further therapy.

22
23 *Was that a hospitalised...?*

24
25 He wasn't, he was somebody who had come here with quite complex – well not complex,
26 but I mean with quite an enduring personality problem I would say, and a depressive
27 disorder. And I treated him largely because he'd...he'd been offered treatment but he
28 caused a lot of trouble, there was somebody who had already come with quite a label
29 having made complaints to the Trust, about the waiting list, and about his treatment with
30 a psychologist. Not necessarily substantiated, but, on the waiting list level, but I don't

31 think the psychologists were nasty to him. But, so, yes, so he looked like he was going to
32 be severe and enduring and difficult to treat, and actually, and I then gave him a bit of
33 treatment. But he seemed to be able to make use of that and that seemed to work.

34
35 *So you, at the outset you decided to give a bit.*

36
37 Yes. And he used it, so we gave him more.

38
39 *So that's your second group of people?*

40
41 Mm. The hospitalised people, I think almost that they, I think that sometimes they drift in
42 because, you treat them when they're in crisis; I think sometimes contracting goes out the
43 window. I mean that's the reality of it, sometimes for me that happens. You sometimes
44 go through, you've been...you're at twelve sessions and you suddenly think, gosh I'm not
45 sure that my formulation on their history is very good, because somehow you've started
46 treating them on activity scheduling or something, and somebody's not in a fit state, and
47 then suddenly you think, gosh, I need to go back to the drawing board. So that can drift.
48 And the reason why I tend to see some of those people for longer is, I often tend to be the
49 only clinician working with them, so, I quite often would become their key worker. I
50 think there are more pressures then.

51
52 *It doesn't sound like a good system.*

53
54 I don't think it's a bad system, but it depends what your aim is really, if your aim is to be
55 a therapist, or whether you're aiming to keep the team happy, or be a key worker, or
56 minimise the number of contacts this person needs with the team. And sometimes it can
57 be quite unwieldy, if you've been a therapist and somebody else has been the key worker,
58 and actually somebody's functioning reasonably OK, ish, and can manage with one
59 worker, I think that's better. Well thinking about two particular in-patients, and one that

60 I'm seeing now and one that I worked with before, and they really did have kind of
61 complex problems.

62
63 *But you didn't see them, you're not counting this as while they were in-patients; this was*
64 *when they were...?*

65
66 This was when they were discharged.

67
68 *...discharged.*

69
70 Yes. Mm. So I'd pick them up when they were.... I've lost track of the questioning.

71
72 *There are two groups, the hospitalised ones and the complex enduring, difficult...*

73
74 Yes.

75
76 *...often with a reputation tag.*

77
78 Yes, and I wouldn't want to say that all my, all my in-patients that I ever pick up get seen
79 for twenty years, they don't, but there are some people where complexity and key
80 working that's two separate kind of issues really.

81
82 [pause]

83
84 *Do you ever decide right at the beginning when you first take them on?*

85
86 For long-term?

87
88 *Mm.*

89

90 [pause] I'm trying to think of a time when I have. I suppose I've not really...I don't know
91 if I overtly would have made that decision. I think sometimes there has a sort of sense of,
92 the likelihood that it would be difficult to offer brief treatment with some people, that sort
93 of, somebody that I saw last year who, although I offered brief treatment as a sort of, a
94 taster or as an experiment to see whether or not they could make use of it, and if it would
95 be of any help to them, I had a very clear idea in my mind that it would be unlikely that
96 that would be the minimum. So the contract with the patient was brief, but actually in my
97 head, and this is somebody who had been, who was a late adolescent and was I think
98 nineteen, and had already been held under a section for two years, and had received a sort
99 of tentative borderline personality disorder diagnosis, although people were reluctant to
100 use it because of her age. And she'd had two years of psychodynamic psychotherapy in
101 the in-patient unit, that she'd been in a private in-patient unit. So although I'd said yes,
102 I'll see her for four to six sessions to see how we get on, I kind of had that sort of sense
103 that it may be difficult to limit it to that, and that she would...she actually found that quite
104 difficult, to trust me, for that brief amount of time.

105

106 *So what happened?*

107

108 She actually dropped out of the treatment in a kind of, almost a flight into health, because
109 she dropped out of my treatment, the psychiatrist's treatment, the GP's treatment, the
110 social worker's treatment, and is now allegedly, apparently – well not allegedly, I do
111 know that she's gone to college, and has, you know, made a success of her life, which is
112 very good.

113

114 *Mm. So you, you rarely actually decide at the outset, rarely if ever...*

115

116 Yes.

117

118 *...I don't think I do, but you might decide fairly early on?*

119

120 Yes. Decide's probably putting it a bit strong, but have an inkling. Yes.

121

122 *So what happens to make you think that give more...?*

123

124 I was thinking about this, as you were summarising me. There are various kind of
125 criteria, and one I think is the one we talked about, which is somebody looking like
126 they're making use of it in a way that makes it seem worth pursuing, and with the person
127 I'm thinking about, actually this was somebody who complained bitterly about the
128 waiting list, complained bitterly about the NHS, have lots of feelings that the Health
129 Service didn't care about them, and then seemed to be, had quite paranoid and fixed
130 beliefs about themselves and the world, and actually seemed to be showing some signs of
131 shift, which, (laughs) which meant that he could make some progress with cognitive
132 therapy. But also meant, and this sounds awful, but, that he could actually leave OK.
133 And I had a sort of, a very strong sense with this chap that when we withdrew therapy,
134 that that would be, if we weren't careful this would just re-evoke all the old beliefs about,
135 nobody cares and they just give me things and take them away, and they're just taking the
136 mick out of me kind of thing. So something about him needing to, me needing to ensure
137 that he had a good solid ending that made him feel somehow kind of cared about, and
138 ready for the ending. So deciding with him, I mean it was partly, I was trying to stick
139 very firmly to boundaries, I thought it was very clear that he needed that, but actually
140 there was a side to it, there was one bit about him needing more and needing more, but
141 lacking in benefit from more, and another one about sort of facilitating a good ending that
142 didn't feel like an abandonment, didn't feel too much like abandonment.

143

144 *So did he know quite a long way ahead then that it was going to end?*

145

146 Yes. I mean we were...he is somebody I was very careful about contracting with, because
147 he's somebody who needed to know where he stood from the outset.

148

149 *So did you extend him, like some people have reviews and then offer another five, and*
150 *review and so on?*

151
152 I only extended it once; I think I asked him... I can't remember how many sessions I
153 offered him, but it was something like... Maybe, I might have extended twice. I think I
154 probably offered six and then reviewed, and then another eight or something, and then
155 around the next review we were coming up towards an ending, and he made a change,
156 and I offered him I think another ten, or twelve, I'm just trying to think. We finished, we
157 were bang on your 26.

158
159 *Definitely twenty-six?*

160
161 Definitely twenty-six. No, it was around about... But, so I only, I did extend him twice
162 probably, I can't remember. Yes, twice.

163
164 *Do you do that with other people?*

165
166 Mostly. My...I mean, not often swayed to extend, but if I've almost got a parallel system,
167 there are the ones that I stick to very firm, and these are the ones you're interested in
168 really, well they are the ones you're interested in. There are a lot of whom I kind of make
169 the decision are sort of, fairly straightforward, and therefore I offer them around the kind
170 of eight, ten, twelve sessions mark, probably, and review every four or five sessions. And
171 then the ones who almost have a kind of, a much more open-ended contract, and there
172 aren't very many that I have like that. But, I mean there's one at the moment where by
173 virtue of complexity it is... I mean this guy's, this guy I talked to you about before, he's
174 got PTSD and chronic depression and a history of childhood abuse, who, you know, I
175 mean one could carry on working with him forever, but at the moment our aim is just to
176 kind of tone him to some sort of level of functioning that's manageable really. But I've
177 been seeing him for over twenty-six sessions since last year, so, weekly for a year, and
178 for longer than one-hour sessions. It's confession time. (laughs) No, I mean I think

there's a good clinical basis for that, this chap kind of can't cope with doing any talking about any trauma or painful things, and then leave. I mean he really does need kind of, a good twenty minutes to get into it and twenty minutes to patch up again before he walks out.

Gosh, I haven't talked about the length of the session time. That's an interesting...

So in terms of client hours, this chap, you know, exceeds people, even though he's only been seen for a year, so technically he's probably had something like the late twenties of sessions, with holidays plus phone calls, but actually in reality in terms of patient hours, a lot more.

[pause] He's only made one phone call but...

Is phone calls something you do?

No, not really. I mean, this person called me in crisis last week because it was sort of hot off the press really. No, I don't routinely. Occasionally, if there's a good reason. I mean usually it would be if I'm doing something where, or I'm sort of busy with clients so that I can't see somebody for a week where I normally would have done. And I think we really need to assess. So it's really a kind of the second best, if I can't manage to see them, but that's very rare. Or if I think somebody's in real crisis and they need some help. But I don't often instigate that, it's usually times when you're ...

[pause]

So what...what makes you decide when to stop?

That's more difficult really.

209 *And I mean with these longer ones mainly.*

210

211 Yes. [pause] It's very difficult. (laughs) I think...I'm just trying to think, I was racking
212 my brains with the people that I finished with after a long, long time. And there's two
213 particular reasons. I think sometimes it's sort of, a sense that somebody's got to a point
214 where they can function without therapy. But that's a very idiosyncratic sort of point isn't
215 it? There's something about, I suppose a concern that you...and it's intuitive I guess,
216 about thinking that you're beginning no longer to offer them something that would help
217 them change; it's more about... I think...I'm thinking about dependency and actually
218 giving somebody a message that they can move on, rather than they need to stay with me
219 forever. [pause] Yes. I'm not terribly clear about that one. And I think those are the
220 main things, I'm still thinking. When you feel like you've kind of, met your treatment
221 goals. I mean, it's difficult with that, because you can always find more treatment goals,
222 but... I'm just mindful of clients I've seen who've been seen forever and ever by people,
223 and they come back and you say, 'Why do you get seen forever and ever?' and they say, 'I
224 don't know, the person made me come back, and that sort of made me feel like I'm a
225 really terrible patient and I must have done something really, really wrong for them to see
226 me for twenty years every six weeks.' But so, a sort of something about giving people the
227 message that they're competent and they can work without a therapist, a sort of clean bill
228 of health kind of thing. So that's about, I mean that's an aim rather than why I make the
229 decision.

230

231 *Yes, what are your aims and goals in therapy?*

232

233 [pause] Well it's just the classical cognitive therapy answer is, well, to help people
234 function in the way that they identify as being a goal for them that would be realistic. So
235 I suppose that's the answer, I don't... [pause] I don't know, they vary. I mean I think
236 with, with one client that I saw, it was to keep her safe, because when I first saw her she
237 was doing quite unsafe things, in a lot of chaos and getting involved in dangerous things.
238 So it was about keeping her, I think for her it was keeping her alive, or, protecting her

239 from being raped. That was my aim, I think. And the chap that I finished work with
240 recently, he'd had quite sort of a lot of anti-social personality traits, it was really to kind
241 of get him to a position of acknowledging his role in his relationships, and the fact that
242 there is a lack of relationships really, and that was quite a challenge, because, to get on
243 board with somebody enough for them, he was quite prickly and found it quite difficult,
244 and felt very angry with the system for letting him down, rejecting him, whatever. So that
245 was an aim really, to get on side, I think that was to get alongside him really, and to
246 develop a relationship where we could be a bit more open and honest about his role. And
247 to that extent we succeeded really. I mean his goal was to earn £100,000 a year, and get a
248 girlfriend, which is a difficult one for him, and we failed. (laughs) But I think we
249 reviewed that goal, and, I don't think his goal was that important at the end really. He
250 was sort of setting goals that were impossible to meet when we first started, but his goal
251 at the end was to move out the family home, which was...

252

253 *A first step.*

254

255 A good first step, yes.

256

257 [pause]

258

259 *I'm interested in the way that complainers get more.*

260

261 Mm.

262

263 *I mean you're not...when I interviewed Joan last year, that was a big category she had.*

264

265 Mm. Yes.

266

267 *Is it just that man, one person?*

268

269 Oh I haven't got any more complainers, I don't think. No.

270

271 *So when you offer more sessions, do you think it might be something about you...*

272

273 Or about them.

274

275 *About them, about your relationship?*

276

277 I'm sure it's all of those, you know, me, them, us. I'd like to think it was based on some
278 sort of clinical need as much as some sort of, kind of, which on my part. And... And it's
279 interesting, because I was just thinking about, I mean the opposite is people who I haven't
280 offered, and hadn't agreed to treat.

281

282 *Yes.*

283

284 And I suppose I'm mindful, I've had some interesting outcomes with that, where, I was
285 just... It almost kind of guides me into thinking, why do I or don't I offer treatment? And
286 I can tell you, can I tell you about a woman that I didn't treat, and she was somebody who
287 had been seen for twenty years every six weeks, and just kind of always had an
288 expectation that she would be seen by the Health Service for her many anxiety,
289 depression type problems. And I didn't offer her treatment on the basis that I felt... So
290 she wouldn't...I thought she wouldn't change. I thought she was dependent on therapy in
291 a way that was, through infantilising and...not infan...what's the right word for kind of,
292 sort of deskilling, and disabling somehow. Because it wasn't enabling. So you were kind
293 of a bit like the expert, and she would trot along and you'd kind of reassure her for a bit,
294 and then she'd go off again. And also she was quite, she would set treatment goals and
295 then kind of solve them the following week, and then made...

296

297 *So you did see her?*

298

299 I saw her very briefly, I saw her for about eight sessions, and she... But when I
300 discharged her, and said that I felt that there was nothing more I could offer her, she was
301 furious, and...and sort of went off and said, 'Well, there's no point in seeing health
302 professionals, we might as well just go it alone and do it ourselves.' And in a sense...

303

304 *That's what happened.*

305

306 That was exactly what we wanted. And although I'm sure, it was kind of like a nasty
307 outcome in the sense that she felt very angry with me, and very let down by me, it almost
308 galvanised her. I mean in the time that I was with the team that I worked with, she didn't
309 come back. And it may have galvanised her into action. So, I suppose, for my own
310 thinking, as we're talking I'm thinking about how...

311

312 *So, so you seem to be saying that for you, therapy or the interaction is about change, not*
313 *about maintenance.*

314

315 Yes.

316

317 *So even the ones that get a lot more, it's about change.*

318

319 Yes. And I don't think I've got...I'm...unless...I haven't necessarily got very high
320 aspirations about how much change, but I suppose, some change, mm. Mm. And I
321 wouldn't carry on...although I talked about key working, I don't think I would carry on
322 seeing somebody as their key worker unless I thought that it needed a psychologist to be
323 doing this work, or a therapist, you know, a psychological therapist, cognitive therapist. I
324 wouldn't take somebody on for maintenance long-term, if I thought that somebody else
325 within the team could be doing that.

326

327 *So to come back to maybe your own reasons, factors from yourself, do you think that*
328 *liking a patient, or feeling guilty, things like that, come into it?*

329
330 Definitely. (laughs) Yes. Oh I've just thought of another person I saw for a long time.
331 She's just been re-referred. (laughs) I suggested perhaps she doesn't need therapy. Yes.
332 It's not often...I suppose, there's gradations of like. It's not often that I see somebody I
333 don't like, and I often see not liking somebody as being a bit of a challenge, because, I
334 usually think that if I don't like somebody, it means I've not got a good formulation of
335 their problems. Because at least if I, if I understand it, I sort of think understanding
336 somebody means that you don't feel as irritated by them, or if you understand what drives
337 their behaviour. It's not always possible, there are some people who I don't like a lot.
338
339 *Do you ever offer them more therapy, more sessions?*
340
341 [pause] I'm just trying to think of the people I didn't like. No, probably not. It's just,
342 I'm sort of squirming a bit and thinking, well is it that... Because I suppose my
343 formulation of that is that if I haven't got a good formulation I don't like them, and, or, if
344 I'm not working well with them I don't like them, because... Perhaps that's very
345 simplistic. That if I can't...sort of, if I can't empathise with them, then I find that
346 frustrating. But I don't know whether... Maybe that I just don't offer people I don't
347 like... Do you know what I mean, I'm just trying to think whether it's just about liking or
348 not liking, whether there's a reason behind that. And that may sound like squirming.
349 And I remember fondly the people I've worked with for a long time. I don't know
350 whether liking them...possibly. I mean there is something about guilt. I mean the chap
351 that complained, I was very mindful of having really understood what was behind his
352 complaining I think, and you know, and he'd...for somebody who was quite so angry and
353 stroppy, had actually shown quite a lot of vulnerability and talked a lot about painful
354 things, and cried and done things like that in sessions, which were, were quite touching I
355 suppose, and I...well I did like him; he was a stroppy person, but I quite like stroppy
356 people. But, but I didn't want to...that was about not wanting to recreate stuff from the
357 past. But I did like him. I just don't know when...
358

359 *So how does guilt come into it?*

360

361 [pause] I just think I'm heavily defended, or I just kind of pretend that there's a clinical
362 reason for this, and try and deny that I have any personal reaction that are absolute
363 balderdash really.

364

365 *Because I can see that guilt might make you give more than you feel you should.*

366

367 Yes. I mean I think guilt...

368

369 *But also liking someone would make you give more...*

370

371 Yes.

372

373 *Or engagement?*

374

375 Yes, I think it's engagement.

376

377 *Not liking sometimes goes with a patient not being engaged.*

378

379 That's, that's kind of what I was trying to articulate, that I suppose if I don't like
380 somebody, it's...it feels like the wrong word; if I feel like we're not on board with each
381 other, then it's hard to work.

382

383 *Although I've offered more in order to get them engaged.*

384

385 Absolutely, yes.

386

387 [pause]

388

389 *And then had to give it up as a bad job.*

390

391 Yes.

392

393 *After a million sessions.*

394

395 Oh really?

396

397 Yes.

398

399 Yes. I'm just kind of muddled about whether engagement ...

400

401 *And the trust issue, which somebody else brought up, that you need a lot of sessions for*
 402 *some people in order for them to start trusting.*

403

404 Yes. I don't...I don't fall for that comment. I don't buy that one... I do it a bit. And then
 405 I sort of said about that patient, the young girl where I knew that offering forty-six
 406 sessions was tricky, and in fact very quickly she challenged that and said, 'What's the
 407 point?' And before I knew it, I'd offered her much more long-term, thinking... I'm just
 408 remembering this. I wasn't lying earlier. (laughs) I'm just recalling that, that she did
 409 take me on about a short contract, and could only really settle into therapy for, she was
 410 on, I think I offered her something like twenty at the beginning, with a, you know, very
 411 clear knowledge that it would be forty, because of... But in fact she didn't use, so she
 412 doesn't quite count for your.

413

414 *No. And she dropped out.*

415

416 She dropped out, yes. So you were asking about trust, that would come into it to some
 417 extent. But I'd be more inclined to offer ten. That's a lie isn't it, because I just offered
 418 twenty. But I wouldn't just offer somebody oodles of therapy just because of an issue of

trust; there would have to be other reasons, you know, very good clinical need, either, you know, in terms of, if there was a kind of classic... in terms of the patient or the service needing it if somebody's been coming in and out of hospital. So there's a sort of argument that actually by seeing them, you might reduce demands on a service in other areas.

Right, so that's another...

Yes. I just suddenly thought of that one.

Yes

I have done that actually, where I suppose change is change-ish as the aim really, then change-change, with more of a maintenance aspect to it. Or I was thinking about people where, there's one woman who you've probably heard about in the team, who works...who I worked with, to see whether she could make use of treatment in a brief contact, concluded that she couldn't, but also concluded that it wasn't a sensible idea to pull out either, because we felt that she...we knew that she didn't do endings well, and that therefore (laughs) we had to do this huge long kind of time-managed ending, having just begun with a sort of brief contact in mind. And that, I mean that was basically that she didn't do endings well, and that she assaulted members of staff, often in a displacement way, she didn't assault the member of staff who left; she assaulted somebody else, and was quite difficult to manage. And, she also, you know, had lots of drug and alcohol problems, and, and ended up in places like the hospital, prison, she was often finding herself into sort of custodial care, and it didn't seem like a good time to pull out. And so, that was a kind of maintenance-ish.

How long did you see her?

448 Nine, ten months. No, you know... I'm just thinking, I was thinking twenty-six sessions
449 is about a year, but it isn't necessarily. I could have seen her for twenty-six sessions.

450

451 *Yes, between six months and a year.*

452

453 Mm. I've kind of meandered, I can't remember what we were talking about.

454

455 *So, there are service needs sometimes.*

456

457 Mm.

458

459 *And, another thing that somebody has brought up is crises, working towards the ending*
460 *and then they have them. Or rather, there's that, or there's the bringing a new crisis*
461 *every week so that you can't stick to your agenda.*

462

463 Mm.

464

465 *And that just keeps it going for far longer.*

466

467 You're right, there is an element of that. I can't recall that being a... My perception is
468 that that's not been a major issue for a lot of the clients I've worked longer with.

469

470 *Or, pressure from, from other professionals, like GPs or health visitors, or OT or nurses*
471 *or doctors or psychiatrists, whatever.*

472

473 Well you, just... It's interesting that, it flashes back, to various people, and I'm just
474 thinking about somebody where that was true, that, that the referral came from Social
475 Services' children and families team, to see somebody who had lots of problems, lots of
476 sort of social problems, and had a history of abuse, and lots of flashbacks, and lots of

interpersonal relationship problems, where I felt that actually it wasn't very fruitful to pursue therapy particularly not about this person's problems.

It wasn't?

It wasn't, no. In fact, you know, we saw quite significant increase in her distress whenever we touched upon those issues. And in a way a lot of the supportive work that she needed was pretty well, very, I mean, really impressively well covered by other professionals within the Social Services network, in the family centre. But there was a real resistance from people outside of the Health Service, from the Social Services Department not to pull out, you know, pull back on the therapy. Although actually the goals that she had identified weren't workable really. So there is a kind of outside agency thing sometimes. Although, I think what I did with that actually was to try and manage it in a number of ways, one by having joint meetings with the Social...I mean it was a team, a community job, you know, community team job. And I went and visited the family centre with, with family centre workers, the social worker involved, and the patient, and the patient's husband and the child, and talked with all of them about managing her distress, and on a monthly basis. And that kept her ticking over for quite a few months, and actually I think was much more helpful, and it made them, they felt helped and supported, and supervised and whatever. And I maintained some contacts. That was kind of a way round it really.

Rather than seeing her individually?

I saw her individually as well, at times, but not...I saw her for a contract of about, I don't know, twelve, fourteen sessions; it wasn't a long-term. But that's kind of how I resisted it really. But why... I mean I think I had very clear reasons; clinically I felt that it wasn't...it wasn't actually...I thought it was damaging to carry on working with her actually. Because she kept wanting to talk about – well she didn't really want to talk about the abuse, but then kind of, felt like everybody wanted her to be there, and

507 somebody had to say no, this isn't the moment really. And then she got pregnant again.
508 Then that was kind of...and nasty, psychotic... So there was all sorts of... In fact there
509 were lots abuse already continuing, so there was like, there was a lot of protection things
510 that needed to be sorted out before doing any explorative work really.

511
512 *What about supervision then, has that influenced you at all in making decisions about*
513 *stopping or carrying on?*

514
515 Much more so latterly as I've got older and wiser really; I'm not sure about the wiser, but
516 as I've got older I think, or more qualified, you don't get more qualified, but more
517 experienced since qualification, I think I, I value other people's opinion about stopping
518 and starting more than I did when I first started out. Often sort of, some supervisor, well-
519 meaning supervisor, saying, 'I don't think you should carry on working with this person'
520 felt quite punitive, and I felt quite misunderstood, and hated the session rule and really
521 resisted them with passion. And I came to the department when there was a very rigid ten
522 sessions, and if you were really lucky you got twenty, kind of attitude, although there was
523 a bit of furtive seeing people for a lot longer than that probably, definitely. But now, you
524 know, supervision, I often would... I mean in some ways be quite comforted, because
525 there's somebody I'm seeing at the moment who's, you know, very sadly I don't think
526 going to change really, and I've worked pretty hard, and in fact he's, he doesn't count as
527 long-term, but he is long-term, because he was seen by somebody who left this team and
528 passed him on to me, after having seen him for about twenty sessions, and I've seen him
529 for another about twelve. And you know, talking to my supervisor about that person and
530 that person saying, 'Oh hang on, you know, at some point you're going to have to
531 conclude, you have to bale out because you're, you know, it isn't going to work, this isn't
532 helping. It isn't changing anything,' I found that really comforting. So... I would quite
533 often... I'm sure I use supervision much more to help me end with somebody, as opposed
534 to...so I'll ask for supervision when I'm stuck, where I may not ask for supervision when
535 I'm offering somebody a contract, or thinking about extending their treatment.

537 *Well that's interesting.*

538

539 I'm sure it is. (laughs)

540

541 *So, do you find that supervision helps you focus more?*

542

543 Mm. Definitely.

544

545 [pause]

546

547 *And what about line management?*

548

549 Well I have a funny situation at the moment, because, as the sector psychologist, I don't
 550 have very much line management, because Y.'s very busy, and X.'s gone, she's not gone,
 551 she's not line manager any more. And in a sense, I suppose it's a different situation,
 552 because, I don't think that the management that I get from the head of department is
 553 asking me how long I'm seeing people. Essentially the interest is, how long's my waiting
 554 list, and how well am I managing my waiting list, rather than, how am I managing
 555 individual clients. I mean, I have a supervisor that I talk that through with. But very
 556 much in only who I bring. So actually I'm not very scrutinised.

557

558 *So, a sort of case management with, in the context of the waiting list, doesn't mean*
 559 *you've done it?*

560

561 No. Apart from in my head.

562

563 *With yourself.*

564

565 Mm.

566

567 *Does that help?*

568

569 Mm. Definitely. I do a lot of it in my car. (laughs) But yes, between...I do a lot of... I
570 don't have a lot of time to think in the sessions, you know, at work, but I do do a lot of
571 thinking about where I'm going with people, and supervising from...because it's three-
572 quarters of an hour from home to here, and I do a lot of preparation in the car, which
573 sounds ridiculous but that's often what I do. And I do quite often sit down and work out
574 my case load and think about where the people are at and their files think about contracts
575 to try and keep tabs on everything. I'm sure I could do more.

576

577 [pause]

578

579 *The only other thing I wanted to mention was that somebody said that they got the*
580 *impression that they were influenced by an early case they had early in their career.*

581

582 Mm.

583

584 *In seeing long-term cases in a certain way, or giving them permission to see some long-*
585 *term cases, and that then, that influence carried on for later cases. And I dare say it*
586 *could work either way; if you were always very encouraged to stop early, you might*
587 *always go on doing that. Or if you got the message, it's OK, sometimes you would*
588 *continue sometimes to extend.*

589

590 So you're thinking about kind of models that I must have got from the beginning?

591

592 *Does that ring a bell with you? Because only one person mentioned that I think.*

593

594 I mean I suppose...I don't know whether it does or it doesn't. When I first started out, I
595 worked in a CMHT where I did have a couple of longer-term clients; I'm not convinced
596 that seeing them for a longer time made an awful lot of difference to the quality of their

597 treatment at that stage. But I was in some sense lucky enough to have permission from
598 my manager to do that, who did have quite a close line on what I was doing. And I
599 worked on identifying, worked somewhere else where we worked with people longer. ...
600 So I wouldn't say, of my case load, I wouldn't say that the majority were long-time work;
601 I would try and keep that to a manageable level, I think.

602

603 *Oh I think everybody does that.*

604

605 Mhm. But I think I'll be less...I think I'll be more clear about what the goals were, and
606 what the reasons for seeing somebody for longer were. I think, I hope. I mean I think
607 those... When I saw people at the beginning, I think guilt and not knowing what the hell
608 to do with people was much more prominent, and... And also not having, not having that
609 sort of sense about how clients actually.... Many clients, although they have lots of
610 problems, do function, and as you have this idea of a focus to start with, I certainly have
611 this idea that somehow it's an integral part of people's lives. And I think, well that's sort
612 arrogant, I mean people function incredibly competently and we aren't part of their lives
613 at all. So I don't feel quite as sort of, concerned that people fall apart without me.

614

615 *Anything else you want to add?*

616

617 [pause] I can't think of anything. No. It's been quite interesting, it's been a bit...a bit
618 challenging. Not in a bad way, but I mean it's just sort of, we don't often sort of think...
619 I'm not sure what I conclude, so it will be interesting to see...

620

621 *Yes, is there anything you would see differently now?*

622

623 [pause] I think it just re-emphasises, and I have to re-emphasise, which is kind of
624 important to the, importance of contracting. And I can think of somebody, the person I'm
625 seeing for the longest term, I have the loosest contract with, and, that may be why then
626 it's very difficult to kind of rein it in and get the contract on the table, and the plan for

627 ending, because it feels like, you know, you're imposing an ending on somebody who's
628 not otherwise had that built into the therapy. And it just re-emphasises yet again that
629 actually picking people up from the ward, you have to be mindful of the, the
630 housekeeping, the setting up therapy, which I often kind of let slip when I think
631 somebody's not ready to cope with that. But then it kind of drifts, and you almost
632 sometimes think, well I don't have a full history here, and I should have. I kind of get
633 into first aid before I get into, you know, formulating properly. And it's just a pitfall, I
634 need to take it away and think about that.

635

636 *OK, anything else?*

637

638 No, I think that'll do.

1why you offered some patients twenty-six or more sessions, it's your decisions I'm
2 particularly interested in.

3
4 Right. I think, in the case of the one we talked about before...

5
6 *The OCD one.*

7
8 ...the OCD lady, it was largely due to the severity of her problem, and the fact that there
9 were a lot of very difficult systemic issues coming in that made it very dif...made
10 treatment extremely difficult. And also that, at one stage there was a thought that she
11 may have to go into hospital, and that was going to be extremely difficult because
12 apparently OCD treatment here, they don't actually really do OCD, and it would have to
13 mean going to the special Unit, which would cause even more trouble in the family. So a
14 lot of it was aimed at keeping her out of hospital, and keeping her with her child. There
15 were also a lot of other people involved who seemed to...

16
17 *The child was quite young was it?*

18
19 Yes, one, or less than one when we started, yes. And there had been some issues, which
20 actually proved to be wrong, about health visitors, not the health visitor that I was
21 involved with, but another health visitor, saying that the baby was very raw from being
22 washed again and again; in fact, I went to a meeting and we found that that was
23 erroneous. And I think the other decision was, my supervisor was very supportive about
24 it, and, there was some feeling as far as I can remember that, when I actually started with
25 her, it was a sort of slight mistake that I got her, because...

26
27 *[inaudible].*

28
29 ...the assessment hadn't, the assessor hadn't really realised quite how bad things were, or
30 whether they...

31

32 *And that was your supervisor that did that?*

33

34 Yes. And in fact probably things had in fact worsened considerably between assessment
35 and seeing her.

36

37 *In what sense would you say that you were, you shouldn't have had her?*

38

39 Because I wasn't experienced enough. But in fact, I think in the end, without being
40 arrogant or anything, I think it was OK in the end, but partly because my supervisor was
41 so supportive, and his speciality is OCD.

42

43 *Oh. So...yes.*

44

45 Mm.

46

47 *At what point then did you realise that it was going to be a more long term case?*

48

49 I think I started to realise right at the beginning, and we discussed it throughout. And one
50 of the points was when we realised that she wouldn't come actually to the team base
51 where I work, because the OCD prevented her from going out of the house, and the first
52 time she came there were a lot of sort of DNAs. And eventually she did come, and then
53 there were more DNAs, and it ended up that we decided that I should go and see her at
54 her house, which I did. And [pause] continuing to discuss it with my supervisor. And
55 one of the things that happened, she had an enormous kind of pressure of speech, so it
56 was almost impossible to say anything for about three or four sessions. And it was very
57 difficult to make agendas and so on, and my supervisor was very helpful about that. And
58 eventually we did a thing that, I think after about the tenth session we had a trainee, and
59 we decided in order to sort of ascertain whether, whether it was worth us keep doing this,
60 and the use of time and so on, to have a concentrated five day thing, and we had one goal,

61 which was actually, it was to make her baby's bottles without all the rituals. Which I did
62 with the help of the trainee. And then that did work, and so then we extended the
63 sessions further after that.

64
65 *Right, so that was like a review...*

66
67 Mm.

68
69 *... to see if she could use it.*

70
71 Yes. Yes.

72
73 *And you had several reviews, didn't you?*

74
75 We had several reviews throughout, probably after the first session, after the fifth session,
76 after the tenth session. [pause] Then it sort of rolled on a bit I think for another, another
77 ten sessions. I think in a way, the last sixteen sessions probably, or the last ten sessions,
78 [pause] I don't think there was much of a review with my supervisor of exactly how many
79 sessions, because it became... I don't know, it was... The whole thing seemed to take on
80 a life of its own in a way, so... In fact it was her really in a way that ended the sessions,
81 because she didn't...she managed to start to go out and everything, and was a lot better,
82 and...and she didn't turn up for quite a lot of appointments, and I discussed with her on
83 the telephone why it all was. And we've agreed not to meet for the time being, but to
84 have a further review in three months' time. You see when I'm talking, I'm thinking
85 about how difficult it is to remember it all, and how, I think with all of the ones that I've
86 had that are long, it hasn't been all that formal, the extending of the sessions.

87
88 *Formal meaning, agreed with a supervisor?*

90 Yes. It hasn't felt very very formal about, I don't know, [inaudible] ten sessions, and I
91 felt I've had a lot of freedom about it, which might be good, might not be good. And I
92 think that might be to do with, in a way with being inexperienced and sort of being
93 allowed to have a bit more of a free rein maybe.

94

95 *But what's made you decide to carry on?*

96

97 [pause]

98

99 *So you weren't being told to stop?*

100

101 No. Well one of the things was the fact that she was making progress. [pause]

102

103 *And you, I think you said she was very motivated as well.*

104

105 She was extremely motivated, and she, yes, she did make excellent progress, and she did
106 everything we planned and so on. But a lot of the time the sessions were, the reason the
107 sessions were so much longer is because there were so many crises, which perhaps were
108 due to my inexperience, I wasn't able to compartmentalise the crises.

109

110 *So crises about something that wasn't OCD?*

111

112 That wasn't OCD. Although the crises always affected the OCD.

113

114 *Yes.*

115

116 Yes, because there was a lot going on in the family. So, there was that. And also I just
117 felt very motivated myself, because the implications of the problem were so enormous.
118 And I think also, subconsciously I was influenced by the health visitor, who rang me an
119 awful lot about it, and, I remember feeling at the time and talking to my supervisor about

120 it that everyone was ringing me up all the time and putting pressure on me, the dad, the
121 mum, the health visitor, the court, the solicitor.

122

123 *Golly, you didn't mention those last time.*

124

125 Oh, right. (laughs)

126

127 *I wasn't aware of those.*

128

129 Yes, the court, because there were some difficulties over whether her husband was
130 allowed to see the child, and he made some sort of allegations that, that the OCD was,
131 was why they split up and why he beat her up, and so on, so on, so... There was a lot of
132 sort of outside pressure.

133

134 *Mm, mm.*

135

136 [pause] Especially from the health visitor, who I sort of got into a relationship with, and...
137 You know, she made a relationship with me that we were both sort of in it together and I
138 had to sort of help her. And I had a lot of help from my supervisor about that, because
139 that was all quite difficult, all the people phoning and... And the family tended to phone
140 and say, 'She's made absolutely no progress at all,' and, me and the patient knew that she
141 had. So there was all kinds of things going on that made it go longer. Although I do
142 think it was good that it went on longer actually in the end. I don't think it was a mistake,
143 but it was...thinking about it the way I'm talking about, I think it was fairly sort of
144 undisciplined in some ways, how it went on, but maybe it had to be.

145

146 *So she decided when to end it, but presumably, it sounds as though you agreed that that*
147 *was the right time.*

148

149 Yes, yes. Because there was a lot going on in the family at the moment. And the fact as I
150 said before, I've just found out that her sister, which I never knew during the treatment,
151 and, her sister had, was, is part of, is a patient of the specialised team at the moment,
152 dealing with issues of child sexual abuse. Which I should imagine is having a major
153 impact on the family and is possibly why she wants to stop for the moment, as well.
154 [pause] And that...yes, the mother was very ambivalent, and trying to scupper treatment
155 some of the time, so there was a lot of stuff about, talking about how to deal with her
156 mother, and what it all meant and so on.

157

158 *So were you tempted to stop earlier?*

159

160 [pause] [quietly] I don't think I was. [pause] I suppose I felt a bit like it, yes. It felt...it
161 felt hopeless at some stages, especially about what was going on in the family, it was such
162 a sort of close intense family, and they kept on trying to do treatments themselves, you
163 know, like, telling her that there wasn't any soap in the all shops in the county, and...
164 And it was also difficult to meet with them, and I sort of felt it was important to meet
165 with them. I was less tempted to stop with her than I have been with other people. I
166 expect, you know, that in hindsight there was probably a lot going on between her and I
167 as well, sort of thing.

168

169 *So there was something between you that enabled you to carry on...*

170

171 Yes.

172

173 *...that encouraged you to carry on.*

174

175 Yes. I mean she was very... [pause] Bringing, bringing me in by saying, 'Oh,' you
176 know, 'I love it when you come,' and all this sort of thing, So... (laughs) There were
177 quite a lot of things going on like that...

178

179 *How did that made you...*

180

181 ...and so much better.

182

183 *How did that make you feel?*

184

185 [pause] Half wanting...well half wanting to be very very careful about it, and we spent a
186 lot of time discussing dependency and so on. And half thinking, oh good, you know, at
187 least somebody's, she thinks somebody's being nice to her. Because she had so much
188 negative input from all over the place. It's really odd talking about it, because now, the
189 second time of talking about it, I feel that it was all quite a, a sort of, I'm very aware of
190 how confused the whole thing was, and how it was difficult to keep the thread of the
191 OCD treatment through all this, it was like sort of, carving a path through a jungle, you
192 know.

193

194 *And also what I remember was, you said at the every end of our last interview, was that*
195 *you'd felt a bit guilty, and that made you carry on, the sort of mixed feelings that one has*
196 *between wanting to carrying to on and wanting to stop.*

197

198 Yes.

199

200 *You feel guilty because you want to stop, so you don't.*

201

202 Carry on more. Yes, yes. Yes, I did feel guilty, and I felt sort of like, deskilled, I felt,
203 well maybe I'm not really up to this anyway, and maybe I've actually, it was somebody
204 else, they wouldn't have, you know, they would have got a lot further by now, and so
205 maybe I should carry on longer, and sort of make up for my lack of skills. Or somebody
206 else could have done this in ten sessions, so I'll sort of make it more, and hopefully that
207 will make me like a very skilled, you know, sort of person. (laughs) Yes. So that was
208 something, yes.

209
210 *Right. Do you think that's changed at all since, since you've qualified, or since before*
211 *you qualified even, that feeling, or is that still there, the same now as earlier?*

212
213 I think it's worse. Yes. As you sort of learn more and more, you become more, I do,
214 become more and more aware of how little you do actually know.

215
216 *So do you think that might influence you into doing longer therapies?*

217
218 In the future? [pause] No.

219
220 *Or even with the people that you're seeing now?*

221
222 I think it does influence me to have more sessions, yes. But I also think it...it makes me
223 concentrate far more on how many sessions, more in the very...

224
225 *What do you call a long term therapy?*

226
227 I would call it about thirty sessions I think.

228
229 *And you said you had some others...*

230
231 Yes.

232
233 *...that you've remembered now.*

234
235 Yes. I have got a guy who was, had post traumatic stress disorder, and, following the
236 death of his son right outside his house, his only son. And it was compounded by, it
237 brought up something that had happened I think a couple of years before, where he found
238 his apprentice, who was also a young boy, hanging in his workshop. And, he also had

239 some sort of, what I feel almost, had an obsessive quality. There were lots and lots of
240 habits to do with staying close to his son, which were becoming like, like obsessive
241 compulsive stuff. And I think the reason, and actually it's interesting talking about more,
242 but I think one of the other reasons is because again of other people, there was so much
243 outside stuff again.

244

245 *Putting pressure on you?*

246

247 Mhm. And there was a CPN who had particularly said, he must have T, you know,
248 and...and who kept on saying to me, 'You'll be absolutely ideal.' She was leaving. And
249 that sort of thing. So there was that kind of feeling of, oh I must, you know, be... You
250 know, she, she really wanted me to do this, and now she's left, and...

251

252 *So what did that make you feel?*

253

254 Yes, under pressure to make it all right for him that his son had died. Because she
255 couldn't, and you know, she... So sort of, under sort of a kind of pressure from her in a
256 way, even though she wasn't there, you know, don't let me down, you know, keep him
257 alive. He was very suicidal as well.

258

259 *So to keep him alive?*

260

261 Yes. And keep his marriage going. So that was...

262

263 *And that's a big responsibility.*

264

265 Mm. Yes.

266

267 *And to pull the rabbit out of a hat, sort of thing.*

268

269 Yes. Yes.

270

271 *Do you think that made you see him for more?*

272

273 Yes. Yes I do think that had an influence on me. But I also think that it was extremely
274 complicated by the just massive grief. Because also, his son had...be a bit difficult this
275 one, because you could quite easily identify him, but, his son had, on the day his son had
276 died, his wife had just come out of hospital with a colostomy operation, just that very
277 second, and then his son was killed outside the house. And, his wife virtually
278 immediately went into A Hospital, and had, I think for about six months, so, another CPN
279 in the team was seeing the wife. But he had had no time to, to grieve, but there were a lot
280 of issues about weakness, and I'm weak, and that was why I've, you know, I'm still
281 grieving after a year, or, so on. So there was, we spent a lot of time not just working on
282 the PTSD but working on things about, your wife has actually spent six months in A
283 Hospital, which might have [inaudible] things along a bit, and... So it's just lots of
284 different issues really to deal with besides the PTSD. And that's really, to put it
285 simplistically, that's why it was long.

286

287 *Was there... So there were outside pressures making it long, and, were there sort of*
288 *inside ones from, but coming from him?*

289

290 [pause] Yes, there were a bit, yes, because... He would say things like, 'Oh it's coming
291 up to my son's birthday,' and I might have been about to say, 'I think, we'll, just contract
292 for another five sessions now,' and then end it when things are going well. And it would
293 make me think, oh dear, better not say that today. So that would sort of, add on another
294 one. Or, 'It's my son's...' something or other, you know.

295

296 *Sort of emotional blackmail.*

297

298 Yes.

299

300 *So were you reviewing with him as you went along?*

301

302 Yes, I reviewed a lot with him. Because he actually very much wanted a structure to
303 everything, and so I was influenced by him. So we reviewed a lot. So, and I mean the
304 whole thing about him in a way was more controlled than the other person. I felt more,
305 you know, that we were sticking to an agenda and a plan much much more.

306

307 *And you say, in this instance, that supervision wasn't such a factor. You were given more*
308 *of a free rein...*

309

310 Yes.

311

312 *...or line management.*

313

314 Yes, more of a free rein, yes.

315

316 *Did you...*

317

318 I think with all three of them I sort of, was given a free rein in a way, and I wonder...

319 [pause] I think I'm very lucky with my supervisor, because I think he's quite sort of
320 trusting, and perhaps thinks that you won't do something completely unnecessary. But in
321 a way that puts some pressure on in a way, because you know that they're trusting you.

322

323 *And then you've got to show that you're trustworthy.*

324

325 Be worthy of the trust, yes. Oh dear, I mustn't take advantage and that sort of, you know.
326 But in fact, funnily enough I'm...all three of the ones that are long, since I met with you,
327 I've ended it with them.

328

329 *Do you think because, something to do with the interview?*

330

331 I don't know, or whether it was to do with that waiting list meeting. I mean part of it was,
332 you know, it was planned anyway, but... But I'm very aware that I've been stricter than I
333 might have been about it, yes.

334

335 *That's interesting.*

336

337 Mm. Actually I haven't quite ended yet with him, but there's only another couple of
338 sessions I think. It is quite interesting.

339

340 *So how many has he had so far?*

341

342 He's had about thirty.

343

344 *And then the third one?*

345

346 The third one was very different, because I think those ones are really quite complex and
347 there were so many other issues and so on. But the third one I think was actually a sort
348 of, sort of error really in a way. But those ones I don't think I would think, God! you
349 know, that was so stupid, that you took so long. Although there are, you know, bits
350 where I think but... But this one I think, I think was. And I think really that, she, she had
351 a personality disorder really. And that I just kept, kept on going and going and going,
352 thinking, surely something is going to make a difference to your mood, and... And, in
353 many ways the whole thing was one of the most unsatisfactory sort of things I've done in
354 a way. But... She was ex-anorexic as well. So... And actually when I see her, this is
355 interesting, when I see her in the waiting room, I think, oh God!

356

357 *Heart sink.*

358

359 Mm. [pause] So, in fact what I've ended up with, I've...I've ended up finishing it with
360 her, which actually had been planned already, and at the moment she's, last-ditch attempt
361 to help her, she's working through Christine Padesky's book, which seemed, which we'd
362 planned out and what would be the best thing, so on. And then giving her some booster
363 sessions in between now and follow up to help her with that.

364

365 *So at what point did you realise?*

366

367 When she...when I realised it was all, not fantastic, was when she told me that she'd been
368 to some kind of strange institute up in C, which had found that actually, all her problems,
369 all her problems were to do with balance or something. And, they'd given her these
370 exercises to do. And a letter came from the people saying, 'Could you offer her support
371 during this time.' To which I said, 'No.' So, that left... Really you should have the notes
372 with you, because it's quite difficult remembering exactly what happened. That left her a
373 sort of three- or four-month gap while this thing was supposedly taking effect.

374

375 *So you didn't see her for that time?*

376

377 No.

378

379 *How many sessions roughly had you had until then?*

380

381 About twelve I think.

382

383 *So, you'd already sort of gone beyond a ten-session point.*

384

385 Mm, yes I had.

386

387 *And how did that happen?*

388

389 [pause] Well I would say it happened because, again because I realised things were more
390 complex than they seemed at first, and you did quite a lot of schema work and stuff like
391 that. And you know, did extend it by, instead of by five, by another seven sort of thing.
392 So... It was all a bit... This is even depressing talking about it; I think she has made a
393 little bit of progress, but...

394

395 *What's depressing?*

396

397 Well just the thought of her sort of thing. (laughs) Very very dependent as well, saying,
398 'You're not going to end it are you, you're not going to end it?' So...

399

400 *So, definite things coming from her that make you carry on.*

401

402 Yes.

403

404 *And making you feel guilty about that?*

405

406 Guilty again, yes. And when you see her in the waiting room, oh my God!

407

408 *Sort of, seeing her against your better judgement?*

409

410 Yes, yes, really, yes.

411

412 *In a way.*

413

414 In a way, yes. I really think that it would have, that was a waste of, you know, National
415 Health time; I could have... With the others, I don't think that, but I think something
416 went on there, I could have, in less than ten sessions what I've, what we've achieved over
417 the period of twenty-four or twenty...no, about twenty... No, I think it's about twenty-six,
418 twenty-seven sessions. And there was a lot of complaining about other professionals,

419 which I think influenced it as well, what rubbish treatment she'd had when she had
420 anorexia, what rubbish doctors, rubbish this that and other, so I think that might have...

421

422 *How did that make you feel?*

423

424 Thinking, I'm going to be not the rubbish one, you know. I'm going to be the one person
425 you don't complain about. So, I think there was that, yes.

426

427 *Anything like, 'I'm going to be the one who's going to do it this time'? Sometimes there's*
428 *this kind of challenge that I'm finally going to be the one.*

429

430 Yes, there's that. I'm finally going to be the one that makes it. They all obviously
431 couldn't find what it really was, and get to the bottom of it, you know, but I will be able
432 to. And then perhaps the feeling each week of, it's got to be this week, imagining there's
433 going to be some tremendous 'ah-ha' mode.

434

435 *So you carry on.*

436

437 Mm.

438

439 *And then, in the end you realise that you were no different from all the others.*

440

441 Yes.

442

443 *I think we've all been there.*

444

445 Yes. (laughs) Yes. Yes.

446

447 *So, so with somebody, we called this carrying on for the wrong reasons.*

448

449 Yes.

450

451 *And, sort of being unable to let go.*

452

453 Very very much carrying on for the wrong reasons. Yes, that one in particular.

454

455 *And even this sort of feeling, well I've spent all these sessions now, and in order not to*

456 *waste them...*

457

458 I'll have to do another one. (laughing)

459

460 *...and I'd better see her some more.*

461

462 Yes, that definitely happened. Oh my God! I've already seen..., and hardly anything has

463 moved. I know, I'll do another... (laughs) So, yes. But...

464

465 *I've spent ninety sessions doing that. Just getting nowhere.*

466

467 But you keep thinking, today's going to be the day, I've got that funny feeling with it,

468 just, we're going to turn round.

469

470 *Now did you discuss her with your supervisor?*

471

472 Well the funny thing is, I'm worrying a bit about, that people will see this actually, and

473 sort of, being very sort of honest about everything, the funny thing is, I didn't really

474 discuss it with him. In some ways I...I wonder if it was sort of a bit of a secret.

475

476 *A shameful secret?*

477

478 A bit, yes. And also that feeling of, oh it's all going badly, I won't mention it now; I'll
479 just wait till the next one when I'm sure I will have...you know, one of my interventions
480 will have been good. I think I did mention her at first, and he was very helpful and
481 saying, 'You will need longer sessions you know, it's...I'm very clearly with personality
482 disorder,' and so on. But then after that, it did become a bit of a sort of, shameful secret,
483 and in fact, it's funny, thinking about it a bit more deeply, she comes at the end of the day
484 when nearly everybody's gone home as well. It's that sort of... Yes. I stopped talking
485 about her after the personality disorder conversation.

486

487 *And he hasn't asked?*

488

489 No he hasn't actually. But we don't, it doesn't really work like that either. No, he
490 doesn't.... I think, oh God! it's... (laughs)

491

492 *Interesting. I think we've all done that probably.*

493

494 Mm.

495

496 *But not so much pressures from outside. It's something that's happening between the two*
497 *of you, the patient and you.*

498

499 Yes. Yes. And also there's a feeling of, if I do mention it at supervision, he might say,
500 'You've got to stop,' or 'I think it would be better if you stopped.' And I've got to make
501 that decision myself, sort of feeling. I can't leave her unless I've...

502

503 *What about, there must have something quite powerful coming from her that...*

504

505 Yes.

506

507 *...you can't stop.*

508
509 [pause] A lot, a lot of crying at any sign of ending.
510
511 [pause]
512
513 *But you have made the decision now?*
514
515 I have made the decision now, yes.
516
517 *And how did that come about?*
518
519 [pause] Oh, actually that is completely wrong. I did speak to him about it, yes I did.
520 And we decided that we, I would say to her, 'Now look, you're not sort of doing the
521 homework, things aren't moving on terribly well. Let's just have three really really
522 concentrated sessions.' And it was after this strange thing that she had been to. 'Let's
523 have three sessions, see how it goes, if you can do the homework, and so on.' And if
524 anything moves. Because, you know, obviously it's, it's no good just car...the only thing
525 that will keep things going is if things are improving, and they're sort of, whatever I'm
526 doing isn't really...what I'm doing isn't helping terribly much. So we went through those
527 three sessions, and during that time, that was when I started her on the Christine Padesky
528 book, and, she did seem to be finding it useful. And then, we actually ended at the third
529 session, and said, she should carry on with working through the book, because it seemed
530 to be the thing that had got her going, but that we would have booster sessions every two
531 or three months, until she had finished the book. And I reiterated about, you know,
532 there's no...there was only any point in us carrying on if things are changing, which in
533 some ways I wish I'd said before. (laughs) Yes. [pause] So yes, out of them all, that's
534 the one that I feel, you know, as you say, the guilty secret a bit. And it's strange about
535 seeing her at the end of the day, but that's what she wants anyway, but you know, sort
536 of...
537

538 *It's important that.*

539

540 Mm. Yes. And I think the other two were much more about such, you know, such a
541 complex set of difficulties, problems, plus lots of other things. Mm. I also think that
542 sometimes, the more you see people, the more...once you do go over it, it can be a bit, just
543 as you say, you know, oh I've gone this far, I've got to do another five now. And then
544 another five. Yes. Yes. Interesting. Do you think that people with more experience
545 or...do it less, or...?

546

547 *I doubt it actually. Although some people are very focused. I mean I personally don't do*
548 *it less. And I'm looking forward to seeing a couple of other people later on who, I just*
549 *don't know if they do or not, but who are very experienced people, and I'm interested to*
550 *hear what they're going to say.*

551

552 Yes.

553

554 *I've got a whole mixture, I've got the whole range of people that I'm interviewing.*

555

556 Yes. Actually, I do think it would have been better, but I don't know whether you do, to
557 have the notes with me. It's quite difficult remembering the exact thing when you're...

558

559 *Well the exact thing doesn't really matter I suppose.*

560

561 No, no. When you reviewed and so on.

562

563 *No, it doesn't really matter.*

564

565 Mm.

566

567 *I think it's getting the general picture of what people do. So would you see things*
568 *differently now, after this interview?*

569
570 Yes, as I say, it's very interesting talking about the third one, the sort of, the guilty secret
571 one, because, I would see it much more that, you know, that it was in some ways a
572 mistake, but I did even before I talked about it. And I feel more positive about the other
573 two actually.

574
575 *Why?*

576
577 Because I tend to think, oh my god! it's so terrible to have so many sessions, you know.
578 The ultimate therapist is the one who can do things in three sessions or less. But when
579 I'm talking about them, I think, God! there was a lot to do, and you know... But the third
580 one I think, oh God!

581
582 *So do you think that then, I mean one drifts along, and feels guilty and gives more, but*
583 *then giving some structure and some concentrated thought to someone might actually*
584 *spur them on? Or is that a red herring as well?*

585
586 I think it might be a bit of a red herring. I think maybe the Christine Padesky book just
587 might be just another way of not letting go. But now you say it, yes. I might be kidding
588 myself that, even after all that help I've given her that book.

589
590 *And I noticed the...*

591
592 And go away. (laughs)

593
594 *I noticed you said you'll see her while she's working through the books, and she might*
595 *end up never quite finishing at all.*

596

597 Yes, I've thought of that, I thought of that the other day. (laughs) And then I'll probably
598 end up saying – well I won't now, because I'm going to be...you know, it's got to be a
599 chapter a week or whatever.

600

601 *Shall we stop there?*

602

603 Yes, yes.

604

605 End of Interview

606

1 [Tape Side A]

2
3*twentysix or more sessions, and it may help you to think about specific patients. But*
4 *it's your decisions that I'm interested in. So... Why did you offer some people more than,*
5 *twenty-six or more sessions?*

6
7 Oh, now that's a difficult question to answer.

8
9 *You can think of different cases.*

10
11 Well this man that I was working with with OCD, who I've offered the most sessions to
12 ever, as far as I can remember, he had such complex OCD that the whole of his life was
13 debilitated, every second involved some kind of ritual, neutralising and mental task. And
14 when we attempted to count them, there were just thousands and thousands and
15 thousands of obsessions. He worked really hard in therapy and actually became quite
16 obsessional about the treatment of OCD, because he'd had a trial of treatment before, and
17 it was mainly the exposure and response prevention treatment. So given that this was
18 more cognitive, he got caught up in the obsession for knowing about the therapy, (laughs)
19 which took quite a long time. So there was that element to it. He also did very well, he
20 managed to get his rituals down to about ten a day, but he found it extremely hard work,
21 and he was extremely depressed. On top of that, I guess he had masses of potential. He
22 was somebody who you could just see, if you took away the OCD, he could do
23 phenomenal things. He was incredibly bright, he was...he was actually a really nice
24 bloke as well, although he had dreadfully low self-esteem, he thought he was dreadful,
25 and lots of his obsessions and rituals were about sort of eternal damnation. So, I guess, a
26 lot of it was about attempting to get him to a more functional state, which we managed,
27 but then, he was extremely distressed still. So, we probably, of the forty-three sessions
28 we probably did about twenty working on the OCD, probably about eight or so on the
29 depression, and then another chunk on self-esteem issues. And a lot of the work at the
30 end was sort of spaced out, and I saw him over...I'm just looking... Oh it was only over a
31 year I saw him, so perhaps it wasn't spaced out as much as I thought.

32

33 *And so, at what point did you decide that he was going to have more sessions?*

34

35 I'm not sure that I can remember. No, it's too long ago for me to remember.

36

37 *Do you think when you first saw him, you were trying to see him in ten?*

38

39 I thought it would be very unlikely that I could see him in ten sessions. This is somebody
40 who was treated by a very senior member of our staff previously, and she saw him for
41 about twenty sessions plus, so, I thought it was unlikely that I'd be able to do anything in
42 ten sessions.

43

44 *So, that must have been right at the beginning then?*

45

46 I think I probably had in my mind that I wouldn't be able to see him in ten sessions at the
47 beginning of therapy.

48

49 *And then, how did it keep going?*

50

51 I think, I would be guessing, because this is what I do now, so I would just guess that
52 what I would have done is, I would have got to a block, say, of ten, and then I would have
53 contracted to do another ten, and another ten, and so on. Although what I imagine is that
54 towards the end, because there was a point where I had to finish, because I was actually
55 going off on maternity leave, I think we probably didn't contract in the last few, and it
56 was just that we'd noted a point where I had to finish.

57

58 *And when you finished, you didn't arrange to see him again when you came back?*

59

60 I didn't think that would be useful at that point, because what was also evident, and
61 became more so, was the dependency issues, which I was always aware of, and I was
62 aware that to some extent as a therapist I was taking some responsibility, which helped

his obsessions. And whilst I was aware of that, and that's not ideal, the aim was for that sort of responsibility to I guess be tapered out. Yes, whilst that wasn't ideal, he was able to do so much more, and he was able to, he started a course at a Farm Centre, which is some kind of agricultural project, he, he managed to go out a little bit more. These are all things that he'd never done, he was pretty much confined to his room. He managed to be able to cook meals. So I kind of felt that it was a balancing act of improving somebody's quality of life, and my taking some responsibility for his, his sort of fears and obsessions. And the idea was that, that was, that responsibility that the therapist was taking would be phased out. Although, as it came toward the end of the therapy, the dependency issues became more and more evident, and he was actually very distressed in therapy. This is a man whose mother committed suicide when he was about, I think he was about five or six years old. [pause] Actually that took a large part of the therapy as well, just attempting to understand all that, and his issues of loss.

What about the other?

There was another man I saw with bipolar disorder, who I saw for thirty-six sessions. I was surprised I saw him for so long, because, he was actually quite a difficult man to work with, and I think I got fatigue of this man. He...I think, it's probably fair to say, and again I'm thinking back a long way, but it took him a long time to stick with the task in hand; although he had bipolar disorder there was lots of other complex problems going on, self-esteem issues, and relationship issues, and it probably took me a large part of the therapy to just get him to stick to the task. And I think perhaps through some very sort of, good supervision with Z. in fact,, and that strategy was just to get him to stick to a task, and I think we were looking at sort of treatment outcome. But it took us a large part of the therapy to get to that stage. And then there was a huge chunk of work that needed to be done around his managing highs, managing lows, managing low self-esteem, and the relationship issues that occurred week in, week out. And again, he was somebody who had very difficult relations with his mother, which he blamed a lot for his illness. But there was just a huge chunk of work to be done with him. And the other person...

94 *So when did you realise that there were no [inaudible], did you decide, how did it come*
95 *about that he got more sessions?*

96

97 [pause] I've just realised that all of these stopped having sessions because I was going
98 off on maternity leave. And what I would imagine with each of them is that, I probably
99 took these people on at a point in my career where I didn't feel so rigid about a ten-
100 session limit. I'm just looking... These all started treatment probably just about three
101 years after I qualified. I would have always contracted with them for a certain number of
102 sessions, but because of the complexity of their problems, and two of the patients that I'm
103 thinking about had bipolar symptoms, so I would have always been thinking in mind of
104 about twenty as a minimum, in the two patients with bipolar symptoms. And for those
105 two where I decided to continue, it was mainly because the tasks didn't get done because
106 of their chaotic nature, I think, and the difficulty of sticking to the task in hand, and I
107 guess my difficulty as a therapist in getting them to stick to the task in hand.

108

109 *Do you think you would do that differently now then?*

110

111 Yes. Yes. I'm not saying I would never give anybody a large amount of sessions, but I,
112 what I learnt from each of those patients were strategies, I guess more sort of, clearer
113 therapeutic strategies, that would give me information about how people might respond
114 to therapy, how to ensure that the patients used the therapy more productively when it's
115 offered, and one of these patients in particular, again with the woman with bipolar
116 disorder, we probably spent the first ten sessions just deciding whether or not she wanted
117 therapy; whereas now I'd be more inclined to say, 'We usually offer people five sessions
118 in the first instance, to see if they can use therapy well.' And, I guess another strategy
119 that I'd learnt with the chap with bipolar disorder, who again struggled to use therapy, or
120 I struggled to help him use therapy in the most constructive way, was that, if I started the
121 session with a, 'How are you?' we'd probably end up having half an hour
122 of...unstructured therapy of him just going over the same kinds of difficulties that he was
123 experiencing week in, week out. So I would have done things differently now. Although
124 I think the one with bipolar disorder did use therapy very constructively, each session,

125 with the exception that he would occasionally come with a little checklist of things that
126 he was concerned about, although we were able to reflect that, of what he was actually
127 doing in therapy was seeking reassurance, and to some extent passing on some of the
128 responsibility to me. [pause] I don't envy you trying to make sense of all this. (laughs)
129 It's very difficult remembering back actually. If it was somebody more recently, I think
130 I'd find it easier to say.

131

132 *What about the other one?*

133

134 Mm. Right. Now I'm pretty certain I would have seen her for more than twenty-six
135 sessions, because I saw her for well over a year, and this was pretty shortly after I
136 qualified. My reasons for... What were the questions again? What were my reasons,
137 what were my reasons for seeing them for longer? Oh well partly because she was
138 extremely disabled by her difficulties. She was at times extremely suicidal, and she had a
139 history of coming in to hospital on a number of occasions for attempted suicide. She
140 again was somebody who struggled to use therapy in the first instance, and there was lots
141 of interpersonal issues that arose through people working with her. So, she was
142 somebody who I had to work quite hard with, creating a team around her; she wasn't
143 somebody who was a CMHT patient, she was, she was seen in outpatients, and she was
144 also seen by another service. So we had to create almost a mini team around her, and
145 provide very consistent support, because she was somebody who would relate one thing
146 to somebody and relate something slightly different to somebody else, and cause all sorts
147 of tensions. So, a lot of the work was joint meetings, although there was, the vast major
148 of the work was individual sessions. I think she benefited from, from the joint meetings,
149 in terms of us offering a very consistent and clear but fair and supportive approach to her.
150 She also gradually began to get better, she began to use therapy, albeit in an unusual way.
151 One of the things that she really needed to work with was issues of low self-esteem, and
152 cognitive strategies to deal with her low mood, although what she used more than
153 anything was behavioural strategies, and they seemed to have quite a useful impact for
154 her. And she, she was just somebody that was, was contained I guess throughout the
155 course of therapy, and I think she was somebody who I saw before I went on my first

156 maternity leave, so this would have been, I would have seen her about four years ago.
157 Yes, I'm sure I saw her straight after I qualified. And when I stopped seeing her, it was
158 the...the consultant in outpatients felt that she ought to be taken over by the team, and
159 actually she went into quite severe decline at that point. I think the system that had
160 contained her seemed to break down, it didn't carry over as well as it could, which could
161 have been a failing on our part, although we did all we could to make sure that that did
162 happen. And she was somebody who then was using, once we'd finished contact, and, I
163 think...I think I possibly saw her for over two years, off and on, and I kept her out of
164 hospital for about two years, but shortly after we'd finished she did start coming back
165 into hospital using a specialised service, and becoming a quite dependent patient again.
166 So there was something about containment and keeping her out of hospital, and keeping
167 her as well as possible, although clearly she wasn't able to utilise strategies to such an
168 extent that she was self-contained with them, in any sense whatsoever. Yes?

169

170 *Right. So, you've sometimes mentioned that the patient was motivated and able to do*
171 *something.*

172

173 Mhm.

174

175 *And you've mentioned that some were difficult, were difficult to work with.*

176

177 Mhm.

178

179 *You've made it sound as though that was a contrast, that the man who wanted to work*
180 *was therefore easier to work with.*

181

182 He was easy to work with in that he was motivated, and very keen, and he would go and
183 read texts. I was being supervised by U., who was obviously very knowledgeable about
184 OCD and she would give various papers, and he was quite into reading various papers, so
185 he was motivated from that point of view. But his motivation was obviously quite

186 obsessional also, so that... I'd say that each patient was difficult to work with, but in
187 different ways.

188
189 *Do you think that that, how you got on with them, was a factor, whether you saw them for*
190 *longer?*

191
192 Yes. Yes.

193
194 *In a positive or a negative way?*

195
196 Both. I think... [pause] a woman that I saw who was depressed had no self-esteem, and
197 a difficult and complicated personality, had struggled to make relationships with people,
198 and the fact that we made a relationship that she began to trust, I actually felt was a
199 positive thing, and it probably aided my decision to see her for more sessions than we
200 would normally offer, because I felt it was necessary to form that relationship before she
201 could make any shifts. [pause] Sorry, I'm just trying to think... The two people with
202 bipolar disorder interestingly were both quite, were both patients who I found quite
203 difficult to work with in that they were quite...there was something quite irritating about
204 both of them, which sounds very unprofessional. [pause] I'm trying to think how that
205 would have kept...how that would have been influential in, for making me keep them on
206 for treatment. I'm not quite sure.

207
208 *Because you have a guilty conscience?*

209
210 [pause] No, I didn't have a guilty conscience, because I... I guess part of the irritation
211 might have been that, they were quite demanding of my time, and quite demanding in
212 wanting more sessions, whereas I felt, I did actually think that they weren't using
213 sessions as well as they could. So I guess the factor that, that kept them on in therapy for
214 a bit longer was to do with their demands, despite not actually using therapy. And for the
215 patient with OCD, I guess one of the, what was the most, the sort of, the relationship, the
216 therapeutic relationship issues was...was that the question

217

218 *Yes, yes.*

219

220 I think the thing that, well the emotional thing for me that kept me wanting to really help
221 this person was that, he was actually a really, really nice person, and he had so much
222 potential, and his life was so sad, and so unfair. It was actually quite distressing. I mean
223 apart from the fact that his mother committed suicide when he was five, he wanted to
224 deal with it by staying with his grandparents, and his father moved him away to live with
225 him, and put in this boarding school, which is so horrible. And he was still just, not able
226 to cope with it. And he blamed himself. So I guess there was all...yes, there was a lot of
227 personal... I did actually feel very personally distressed by his story.

228

229 *Well it's sometimes something to do the patient, they're demanding it.*

230

231 *Mhm.*

232

233 *And sometimes it's the relationship between you, like building up trust between you*
234 *before you can even get going. And do you think it's also something to do with you?*

235

236 [pause] Yes, although, I don't get the, the feeling... I mean these were people who I took
237 to supervision very regularly, and I didn't get the impression that they were exclusive to
238 me, the facts were exclusive to me. And the chap with OCD regularly went...in fact U.
239 supervised me solely on that case, because it was shortly after I qualified, and he was
240 somebody who was identified as being one of the most complex people who had been
241 assessed through that service. And she, I could see that she... Gosh, actually I....yes,
242 mm, you might have to scrap this on the tape, because I shouldn't be identifying names
243 there, but...

244

245 *They'll be obliterated.*

246

247 Right, OK, that's fine. But she also took on board this idea that, oh it would be so good if
248 we could help this person just that bit more, because he's obviously doing really well.
249 And yes, I think she could recognise the potential if we just took away the OCD.

250

251 *So that was almost like supervision pressures, to go on seeing him?*

252

253 Not supervision pressures, but supervision support. [pause] And also for one of the
254 patients, a person with bipolar, there was a lot of...there was a lot of outside pressure
255 from her family and the system, because she was somebody who was fairly well known
256 to the system, and there was some kind of connection with services as well.

257

258 *What's the difference between the system or the services?*

259

260 I'm just trying... She was an anonymous patient, I'm just trying to be quite careful.
261 There were contacts with the system. [pause] There was a, I guess there was a pressure
262 from the mental health system for this woman to receive an adequate service.

263

264 [pause]

265

266 *Right. And you've mentioned the system in the sense of having a team that was*
267 *supporting you, but did you get pressures from the team to see anyone, or to carry on*
268 *seeing anyone?*

269

270 No. No. Although, one of the difficulties I think for all of these patients to some extent
271 was the kind of work that could be done in a sort of maintenance role, and who was
272 available to do that. For one of the people there was a bit of pressure for me to start
273 seeing them again in fact, and I'm resistant to do that, and it's fortunate that in our team
274 there's somebody who's quite interested in CBT and quite knowledgeable about CBT,
275 and what I'm actually doing is supporting her in continuing the work that we've done, as
276 opposed to me getting in there and re-doing it.

277

278 *Why do you think you don't want to see them again? Because you gave them so many*
279 *sessions?*

280
281 Yes, and I didn't feel that they used sessions as... [pause] In an ideal world where there
282 wasn't pressure on services, I think there were good pieces of psychological work that
283 could be done. Given the current climate where there's a pressure on services, I feel that
284 what we can do is, we can offer brief cognitive therapy, and we can train people in
285 strategies, cognitive therapy strategies, and I think that's about all we're able to offer with
286 the current pressure on services. This person in particular who's asking for more work
287 had all sorts of self-esteem issues; the main issue was coming to terms with her life now
288 she had this diagnosis. Again this was somebody who was extremely bright, had
289 potential to go really far, and she's not only dealing with coming to terms with having a
290 lifelong psychotic illness, in terms of the bipolar affective disorder, but the sort of social
291 slide, that she's not going to be a great musician or a great geologist or whatever; she is
292 going to be a patient with mental health problems. And a lot of our work was really
293 working and coming to terms with that, what it meant for her, all the self-esteem issues.
294 There's also lots of issues about relationships for her, and I would say another big chunk
295 of our work was about her coming to terms with a relationship that hadn't worked out,
296 and quite an abusive relationship that was all tied up in the mental health system also. So
297 they were, I saw them as good pieces of psychological work, because they were using not
298 only CBT strategies but other strategies that we've, we developed during our training, so,
299 in sort of systemic and more sort of dynamic styles of thinking. But I just feel that the
300 pressure on services doesn't allow us to offer that kind of work when we've got waiting
301 lists of x number of months. [pause] And likewise for the other patient with bipolar.

302
303 *About seeing them again?*

304
305 Well he, yes, there's been no request for him to be seen again. But I do think that
306 there's... Even if we're not offering straightforward CBT to patients, there's something
307 more that we've gained through our training that other people in the CMHT can't
308 necessary offer, or don't...whether they can't or they simply don't offer it, is another

matter. But certainly when I've suggested that things like coming to terms with their sort of position in life, coming to terms with their mental health problem, could be explored in a slightly different framework, I think people have just found it's not been particularly helpful to do that with other professionals, and that's not me meaning to slag off professionals. I think that's part...

But you see that that's an important part of what...an important thing for the patient to do?

Mm. Yes. Yes. Particularly people who have got long-term, yes, lifelong problems.

So not formulating into problem-focussed CBT work, but looking at wider issues of the person.

Mhm

You feel that's something that you as a psychologist are better able to offer than other team members?

I have been told that it's been more structured than what other members of the CMHT have offered, and more helpful. Because I guess we are using cognitive therapy strategies, because a lot of the work is self-esteem stuff, it's about people perceiving that they're at the bottom of the heap because they have a long-term severe mental illness, whatever kind of severe mental illness that might be, from OCD, complex personality, or a psychotic or bipolar affective illness. There's a huge quantity of people out there with those kinds of diagnoses that have this perception that they're at the bottom of the heap. And all the things about what...I mean all the potential to do that sort of Padesky type self-esteem work, what makes them at the bottom of the heap, somebody who's not able to have normal friendships, normal relationships, a job, these all apply to these people, withdrawn people who don't have jobs, they don't have relationships, they don't have

339 really friendships. And it's actually quite difficult to work in challenging that, I think
340 it's...it presents a huge challenge to me as a therapist.

341

342 *But you see it as something that you should be doing?*

343

344 Yes, because...

345

346 *Not just working on the OCD rituals but these wider things as well.*

347

348 Mm. I think in an ideal world it's something that we could offer, and it's probably
349 something that I started to offer these patients when I was sort of earlier in my career; as
350 one becomes more aware of wait lists and the importance of people going through wait
351 lists quite quickly, one feels less inclined to be, to offer that.

352

353 [pause]

354

355 *So that's really the pressure from the system.*

356

357 Mm.

358

359 *What about supervision, you've mentioned it a few times as keeping you, Z. keeping you*
360 *focused, U. supporting you.*

361

362 Yes, I haven't had any supervision for a while. I can't remember when I last had any.

363 Oh, what about it?

364

365 *Well, has that played a part in the number of sessions that you gave, in keeping you*
366 *going, or keeping you extending the therapy, or stopping the therapy?*

367

368 For each of the people I've mentioned, I think supervision was probably being sought
369 more frequently, and I would say that each supervisor supported the ongoing work that

370 went on with each patient. So it was never a sort of, an independent decision I made to
371 see each of these patients; it would have been. It would have been something that arose
372 from supervision for each of them.

373

374 *So the decision to carry on.*

375

376 The decision to carry on would have been discussed in supervision for each of them.

377

378 [pause]

379

380 *And did it help you to stop? Well your maternity leave sounds as though that was the*
381 *deciding factor.*

382

383 (laughs) Unfortunately for each of these patients, I stopped seeing them all because I
384 went on maternity leave. Although... Do I really want this recorded? I think, again it's
385 this sort of, this process of learning how to contain such complex patients. And it was
386 interesting that when we had an end point, and we had to work towards it, and there was
387 no option to extend it, that more work seemed to get done. So, therefore I think I'm now
388 less likely to see people as long, because I'm much more rigid and clear about offering a
389 specific number of sessions, and often say at the beginning of the session, as we start to
390 sort of get quite into it, 'Well this is session number eight now,' 'This is session number
391 nine now,' or 'We've been meeting for nine sessions now, we need to review this week,
392 or whatever.' So I think there has been a learning process on my part.

393

394 *What do you call long term now?*

395

396 Over ten sessions.

397

398 *How much over?*

399

400 [pause] Well I have set in my mind that I will work with most referrals with Axis I
401 disorders for ten sessions, and people with psychosis, which would include bipolar, for
402 about twenty sessions, because they seem to be guidelines, and the ten sessions are set,
403 the guideline set by this department. Twenty sessions seems to be the average number of
404 sessions that is offered to people with psychosis, if you look nationally, that's how
405 research studies et cetera. And so I have that figure in my head. Because people will
406 often say to me, 'Oh how long do you think this will take?' It will be rare for me to do a
407 piece of work in ten sessions, it usually kind of creeps up a few more than that. And ditto
408 twenty, it all seems to creep up a few more than that.

409

410 *And in the past, what did you see as long term, was that different?*

411

412 I think generally I would have thought anything over twenty was long term.

413

414 [pause]

415

416 *So, somebody mentioned that long term people were seen like a shameful secret; did it*
417 *feel like that to you?*

418

419 [pause] It doesn't feel like a shameful secret. When I'm relating it to you now, some of
420 it feels like, that a lack of experience played a role, and perhaps a lack of awareness about
421 the pressure on services. It's almost like a sort of, painful awakening to the reality of
422 what we can actually do, because... And the ones I've concentrated on, the four I've
423 concentrated on the most today, I think with a bit more structure, two of them I could
424 have possibly reduced the sessions by, I don't know, five or so, but two of them, the other
425 two, I think the work was quite important, and it would have been difficult, I think it
426 would have been difficult to give them less. And what...what I'm now faced with is,
427 when I look at the wait list, and I see people with complex, very long-term problems, I
428 sort of feel a bit of a heart sink, what can we do with this patient in ten sessions? Not a
429 lot. Therefore, what can we offer them really? There's been a complete shift in my mind
430 as to, what can I do to help this patient, what can I do to help this patient help themselves,

431 as to, how on earth are we going to get this patient through the wait list quickly? How on
 432 earth are we going to get them functioning with the limited number of sessions that we're
 433 able to offer? So it's more of a...it's more of a cognitive shift on my part now.

434

435 *What about line management?*

436

437 What about it?

438

439 *Did that have any influence on the number of sessions you gave to those particular four,*
 440 *or others?*

441

442 Well, for those four, the line management would have been the same as supervision
 443 practically, not necessarily for all. So, yes it would have been influential in that it would
 444 have been supported. Whereas now, I think line management is more interested...well
 445 not necessarily more interested, but that the thrust of the moment seems to be about
 446 reducing wait times. And I'm sure that if one was to expand on that, it's reducing wait
 447 times, yet offering people a high quality service, but sometimes I think that's quite
 448 difficult to do with people who have got very longstanding complex needs.

449

450 *Yes, it's quite a dilemma isn't it.*

451

452 Mhm.

453

454 *It's all impossibilities.*

455

456 Mm.

457

458 *So, it doesn't sound as though you had that feeling of, coming from the patient, like a*
 459 *countertransference feeling, I must rescue this person?*

460

461 [pause] No, that wouldn't be true to say that. I think...I think people generally that I've
462 seen for a lot longer have a big rescue me pull, and I think that can still hook its way into
463 me. Although I'm acutely aware of when it's happening.

464

465 *So what do you do?*

466

467 I take it to supervision. (laughs)

468

469 [pause]

470

471 *So as not to give in to it? Or to give...*

472

473 Not so as not to give in, but to make sure I separate that from, can I do some useful work
474 here, or am I simply trying to rescue this person? Can we do some useful work together?
475 But the chap with OCD, I desperately wanted to rescue, although we could also do some
476 really useful work. And there's somebody also at the moment I'm working with who
477 I've got a rescue-me feeling, but I mean other people who've worked with this man also
478 can see that. I think for me it's particularly difficult when people have experienced a
479 huge social slide, it's almost like an added problem that they've got.

480

481 *Is that something that particularly speaks to you?*

482

483 I think so, yes.

484

485 *Mm.*

486

487 Yes, I guess it's just seeing wasted potential.

488

489 *What about those people where one feels I'm going to be the one?*

490

491 [End of Tape Side A]

492

493 [Tape Side B]

494

495 And...

496

497 *Like, I imagine those people have had – well you have mentioned some of them, have had*
498 *previous therapies.*

499

500 Yes.

501

502 *And even quite, very experienced therapists.*

503

504 In fact, it doesn't ring...it doesn't ring true completely. Although I do remember a person
505 with OCD, the person who treated the person with OCD saying to me, 'I feel really bad,
506 because I was the first person to see them, and I didn't help them.' And I remember
507 thinking then, oh that's probably a little bit like me feeling the need to really want to help
508 this person. I guess it's...it's not so much, all the previous therapies haven't worked,
509 therefore I'm going to be the one to do it, but it's more like, I can't give this person
510 another failure experience of therapy, or I think it would be really bad for this person to
511 have another failure experience of therapy.

512

513 *Right. So that spurs you on?*

514

515 Mhm. [pause] This man with OCD had been an inpatient, he'd had, he'd gone through
516 all the sort of, the kind of specialist type behavioural programmes, and then he'd seen
517 somebody in this department for, I don't know, a huge chunk of sessions, but he'd had
518 very old-style behavioural sort of therapy, and I think a large part of our work at the
519 beginning was, that was him trying to work out that if he'd had the treatment of choice at
520 the time, and it hadn't worked, what was happening now, if there was a new treatment of
521 choice, if cognitive therapy was the new treatment of choice, and what if that was to be
522 sort of, changed in the future? And his sort of attempting to understand that. I get the

523 impression it was probably like, do people, know what on earth they're doing with me.

524 (laughs) But the cognitive therapy made a lot more sense to him, because it took on

525 board the thoughts and feelings and beliefs that he had.

526

527 *So, is there anything else you want to tell me?*

528

529 (laughs) No I don't think so.

530

531 *How do you feel now, having told me those things?*

532

533 [pause] I think it's... The questions that you've asked have been more difficult for me to
534 think about, because it seems like a long time ago, even though it's probably only, well it
535 was about two years ago I stopped seeing these people, so it's difficult to be clear.

536 Although throughout the course I've remembered more and more details that have helped
537 me to sort of, clarify my answers. I think if we were to do the interview again, and record
538 it again, I could probably be clearer and more concise, but I've just kind of rambled on,
539 sort of helped my thought processes that way. I feel certain that I will be identified.

540

541 *Is there anything you would see differently now as a result of talking about it?*

542

543 [pause] I guess the first question was, why did I decide to see these people for longer?
544 And I guess my clearer answer would be that, there was a large piece of psychological
545 work that could be done, that I could offer, if it was supported by supervisors and line
546 managers and services, and I was less aware of the pressure to see people quicker. I was,
547 I was much more caught in the, fairly...I mean I was fairly newly qualified, I stopped
548 seeing these people two years ago, I must have been just about, I think I was just about
549 two and a half years qualified or so when I started to see these people, so I was still in the
550 sort of slightly idealised role of...the role of the psychologist is to enable people to help
551 themselves, and we shouldn't be sort of pressurised to do that in x number of sessions.
552 So I think I would have just been clearer, and less rambling.

553

554 *Anything you would do differently now?*

555

556 *As a...?*

557

558 *As a result of thinking about it here.*

559

560 *Anything I'd do differently with these patients, or...?*

561

562 *Or in the future.*

563

564 *In future? Other than...I mean I think I've already said that I'm, as part of a learning*
565 *process, I'm now much clearer about setting session limits, contracting in, checking out*
566 *that people can use therapy. I guess before, I wasn't so clear about that when I first*
567 *started working, I wasn't so clear about that.*

568

569 *OK, shall we stop there?*

570

571 *Please do.*

572

573 End of Interview

574

1 *I'd like to ask you about why you've offered people that many, patients, that many*
2 *sessions, twenty-six or more, and it may help you to think about specific patients, but*
3 *what I'm interested in is your decisions about that, why you did that.*

4
5 I suppose it stems largely from the fact that I'm working over that period of time
6 principally on my own; there's been some help in the last ten years, not sufficient, so I've
7 still been busy. And in that respect, being in Fourth Team away from the city here, which
8 has got various other, both components to the Health Service, but also other agencies
9 helping people in a diverse range of ways, up in D. often there isn't anyone else. So,
10 sometimes you might handle people that can maybe go elsewhere in a larger set-up. I
11 think also, over the years one has started to work with patients with increasing severity,
12 and I think, again maybe just circumstantial or D. in particular, I think has quite a
13 developed counselling – no, not counselling psychology, counselling service, in many GP
14 practices. And I think it is fairly common, and I've been particularly aware of it over
15 these last few years, of increasing difficulty finding cases simple enough, say, for trainees,
16 that they tend I think to go to the counselling service more, and more and more severe
17 particularly so-called personality disorder patients are getting referred to our service, and
18 often then finish with me. [pause] I suppose also I offer people more than twenty-six
19 sessions when they're far from very much better, but one's still either, in the possession
20 of evidence they're still improving, though one anticipates that slightly. And I suppose
21 there are some patients who...

22
23 *So you go on seeing them because they're getting better?*

24
25 Yes. It doesn't seem sensible to cut out half the tumour.

26
27 *Right, right.*

28
29 And, and I'm sure there are some cases who, there is an element of more practical day-to-
30 day support. It varies a bit with people like say, some borderline, some borderlines you're

maybe trying to do fundamental work, but others you're just trying to keep them out of hospital, stop them self-harming, and that can be a rather lengthy, erratic course. [pause] So, I haven't done any preplanning or thinking, about this, I'm just speaking off the top of my head, and I shall stop there.

That's fine, that's absolutely fine. So do...at what stage do you decide that they're going to have more sessions? Is that something you know straight away, or that happens as you go along?

No, I mean it's an evolving process I think, you know. From the beginning in most cases you have some sort of prediction about the problem, how long it might take I think; everyone's different, circumstances are different. And often of course there's...not infrequently the case you start off with isn't the case you finish up with. They either divulge, or other circumstances reveal maybe greater pathology than you first thought.

So, do you go through a process, like some people do, of having five sessions and reviewing, or ten sessions and reviewing?

It's not formal. I think one's reviewing all the time. I think one reviews what one's doing each session, where you're at, and where you're going. I don't make that's always explicit to the patient, but... Most cases one will start off by saying, we'll have a few sessions and see where we are, see what we can offer them.

And what then makes you decide?

Sorry?

After a few sessions.

60 Well, I mean, one of the things is whether they're actually still attending. (laughs) That
61 doesn't always happen, does it?

62

63 *No. Especially those sort of people.*

64

65 That who've, you know, you've formed a judgement in many ways, that is, there is a
66 working relationship there, a collaborative working relationship and productive. That's
67 it's practical from their point of view; I mean there is sometimes problems of access to
68 the clinic. And I do very little in the way of domiciliary visits, but, I think there are three
69 at the moment who I see in their homes, because of, for a variety of reasons why they
70 can't actually get to the clinic. But, you have to keep a limit on that obviously, or you'd
71 spend half your time charging through travelling expenses.

72

73 *That's no bad thing. (laughs) So you think it's partly because other services aren't*
74 *available in D. and that, that's a big factor?*

75

76 I don't think it's a big factor, but... There doesn't seem to be anywhere else for moderate
77 and severe personality disorders for example, which is a big wedge. I don't...I try not to
78 take them all on, obviously; those of whom eating disorders is a component, we try and
79 smuggle down to E.. (laughs) It's not my favourite condition, eating disorder. (laughs)
80 But, you know, there isn't a range of expertise available which we feel is adequate to
81 meet these people's needs. And certainly, even when I have had help of my own in the
82 past, people have professed an interest in some of these more severe cases.

83

84 *You mean other professionals?*

85

86 Other clinical psychologists I've had working with me, they've either been relatively
87 young or inexperienced, and one has felt that whilst their technical personal knowledge
88 may be more than adequate for the job, sometimes a burden of coping with suicide people
89 is not something you want to rest on their shoulders, so you carry that lot.

90

91 [pause]

92

93 *Does that sometimes make you cut the therapy short, or shorter, because it's a burden?*

94

95 No, it's a burden on them.

96

97 *Well, isn't it also a burden on you?*

98

99 No. (laughs) No, no, never do that, it's my job. [pause] What's so funny about that?

100 (laughs) It's not a burden, I like working.

101

102 *Are there...are there other pressures from, from other services or other professionals or*103 *teams or, that kind of thing, that also push you into seeing patients for longer, or those*104 *kinds of patients?*

105

106 Those kinds of patients, certainly, yes, and I think, you can see them dribbling through

107 various referral routes and just finishing up in clinical psychology. (laughs) Particularly

108 from psychiatry. But quite often other people will get a bit stuck, or they're

109 overwhelmed. Not always, I mean I think they manage often very well, but, quite often

110 come from that source as well.

111

112 *Do you feel that's a pressure though, or a pressure to go on seeing them?*

113

114 I think, I now feel it's a pressure for two reasons, as I'm working half-time, and plus, I

115 have a trainee at the moment and a half-time person still pursuing statements of

116 equivalence, and feeling that they have to have very straightforward cases, and my half-

117 time therefore isn't sufficient to meet that need, and the waiting list is a bit of a farce,

118 although I'm beginning to get to grips with it again. So that is a problem. Another

119 problem that raises itself automatically in my mind is that some of these people you

would certainly, if you're going to continue taking on such cases, you have to anticipate being in post a considerable amount of time, because it is my view that for some of them certainly there is a period of what I would call, like Jeff Young, limited reparenting, a bit of attachment issues, other people might call dependence. (laughs) Which takes a while to work through, and it's absolutely, totally unprofessional to abandon them in the midst of that. So, at my stage of my career, that is a factor that I'm feeling at the moment as well, so not letting myself take any more, though I've taken two in the last week.

(laughs)

So there aren't other professionals who are saying, you must go on seeing this person, you can't stop?

Don't say must go on, of course not; there are people there in need. We're a small team, and we all scrabble around trying to meet it as best we can.

So, you've said that it's partly coming from the...well not coming from the patients, it's the type of patient... I mean...

Those who I take on for a long time, yes. I mean I've been perhaps, particularly thinking of the moderate severe so-called personality disorder. I see there's an article of Ian James in the current *Behavioural Psychotherapy*, objecting to schema therapy swamping the world. (laughs)

Yes, I saw that.

Yes. But certainly... You know, when you get severe obsessional disorders, you know, there's all sorts of severe and/or chronic conditions which lead to a longer-term involvement than would happen with more simple, straightforward Axis I disorders.

149 *But could it also be something about the patient, about how they are, how...not just the*
150 *relationship, but how, factors of the patient, like, they're very motivated, or not*
151 *motivated, or...?*

152
153 Well the right thing if they're very motivated, that they shoot through a bit quicker. And,
154 the unmotivated, I think one, you know, has to recognise that if attempts to motivate them
155 fail over a fairly brief period of time, then one just shuffles them into day services or
156 something like that to get some social psychological programme or support for
157 something.

158
159 *So, and you did say the relationship was a relevant factor.*

160
161 Yes. [pause] I think it has been throughout my working life, everywhere, with any
162 human being I meet. (laughs)

163
164 *So, so...so does that mean that, if you like them or like them less, they might get different*
165 *numbers of sessions?*

166
167 [pause] I don't think so, no, I can't think of any of that. There are one or two patients
168 have, I've just had that feeling inside, you know, of how they must feel. But that makes
169 me more determined to sort it out, help, rather than retreat and avoid them. It's very rare.

170
171 *Any factors to do with you?*

172
173 I'm dogged. (laughs)

174
175 *I mean, you...to me, you seem to be saying quite a lot of things about yourself that make*
176 *you carry on seeing patients for a long time.*

177

178 Of course, I think, you know, people you want to provide the best help you can. I'm not
179 saying I'm highly effective and efficient, you know, I could work harder, certainly a lot
180 better on many occasions. But, there are needy people, and it's very pleasant when they
181 go out the door smiling. I find that rewarding, and that overlaps with my job
182 responsibility. (laughs)

183

184 *So you get something out of it.*

185

186 Oh! [pause] Something. (laughs)

187

188 *Something. You never find it a burden?*

189

190 No. I'm not saying on a Monday morning I might prefer to play a game. (laughs) Which
191 I can do now I'm working half-time. But I've never minded going to work, and certainly
192 have never minded working with patients. The only two glitches I can feel in my
193 professional life have both been with others, trying to deal with awkward colleagues, and
194 latterly increasing frustration with structure and management in the Health Service, and
195 our Trust. That's the burden.

196

197 *Do you, do you ever carry on in the sense that you're hoping they're going to get better,*
198 *so you carry on a bit more, and you still go on hoping and then you come to the point of*
199 *no return and you think, I've put so much in, I can't stop now, so I'd better carry on?*

200

201 Yes, I mean, depends what you mean by better. I mean I think one has variable targets
202 according to the person and their circumstances. I'm working with a chap just now who I
203 have known for almost five years, and who was an inpatient for two and a half years, and
204 my ambition for him is to get him able to go and take his dog out, getting his dog and
205 taking it out for a walk. At the moment he's still terrorised from leaving his house. I see
206 him once one week, twice another week, the specialised team see him other days contain
207 him in the community. They sort of, take him to the dentist and things like that, I try to

208 do something with his psychological state. So my target there may not be realised, but I
209 still think that it's possible. So what I'm saying, the work is entirely to support him until
210 he's better; sometimes it's to stop them killing themselves, and sometimes it's to get back
211 into work.

212

213 *So you don't have that experience of, you're on a hiding to nothing, that you've put all*
214 *this work in and nothing...nothing you're still not...*

215

216 Oh no, many people have stopped attending, and many people which we've decided,
217 we're not going to get any further, at various stages, of six sessions or sixteen sessions, or
218 twenty-six, is that the magic number?

219

220 *Yes. (laughter)*

221

222 Of course.

223

224 *So what makes you decide to stop?*

225

226 Well it depends obviously on social supports, the network they're in, what other services
227 are available and what they're doing. So it's a complex matrix. But basically, you stop
228 when you feel you're not going to improve matters, and you've got them to a functional
229 level that you feel you can't improve, and that they're safe. And hope they'll not make so
230 much demand on other services, maybe primary care or secondary care, in the future. So
231 there are people I see two or three times. (laughs)

232

233 *I mean do you have the...do you have the kind of ten session thing in your mind at all, and*
234 *the waiting list?*

235

236 I've had the waiting list on my mind for twenty years [inaudible].

237

238 *What?*

239

240 I've had the waiting list in my mind for twenty years [inaudible]. And it's something I've
241 had to carry myself.

242

243 *Well in the sense of thinking, I've got this waiting list, I'd better stop with this person, or*
244 *not continue with it.*

245

246 It seems daft...you know... All the time.

247

248 *So you sort of ignore the waiting list?*

249

250 Well not ignore it, you have to take account you've got to keep people moving through,
251 yes. But you don't stop treating someone to treat someone else. (laughs)

252

253 *So once you're seeing somebody, you're sort of, it sounds as though you're committed to*
254 *them, to get somewhere, even if it's a very small...*

255

256 Oh, one...one looks at them and works with them, and if it seems they're not getting
257 anywhere, then you sort of shut up shop on that particular individual, or you'd just be
258 plugging away mindlessly. But if there is scope for improvement, improvement, and
259 there still is evidence of movement, then you stick at it.

260

261 *So what do you call long term therapy?*

262

263 Long term would be certainly, six months plus.

264

265 *How many sessions is that?*

266

267 Well it depends, I normally see people initially weekly, then perhaps fortnightly, and
268 then, depending on the individual...

269

270 *So sort of, twenty?*

271

272 Oh not as much as that, no.

273

274 *Less than twenty?*

275

276 I mean the last time, in the middle Nineties, I made presentation here, and I counted up
277 my average patient contact session and it was 9.1. Now, I think it would be more than
278 that since I've discovered schema focussed therapy. (laughs) But nevertheless, it's, you
279 know, it's...there's a wide, wide range of complex issues.

280

281 [pause]

282

283 *Do you think you sometimes carry on because you can't let go?*

284

285 Oh it depends what you mean by can't let go. I'm reluctant to let go if I feel there's still
286 something to be squeezed out of the situation. I'd like to think that it's not because I
287 can't tell people we're stopping; I do that all the time with others. I think, I work with
288 some patients, like most clinical psychologists, in a degree of isolation, although I do
289 have trainees for six months every year, and... So there is a small part of my caseload
290 which is relatively unmonitored, you know, You can do your rating scales and things but
291 that doesn't tell the whole story I don't think. But, the sorts of people that we're talking
292 about usually have got other parts of the service in contact, involved, particularly CPNs
293 and psychiatrists, and a psychiatrist who refers me a lot of his cases, and in the next door
294 room to me we try to manage these cases frequently. So, there's a lot of discussion and
295 monitoring all the way through the whole process. Does that make sense?

296

297 *Mhm. Mhm. Yes, I was sort of going to come on to that.*

298

299 So, the basic problem really is being persuaded to take them rather than hanging on to
300 them. (laughs)

301

302 *So that implies that you do know before you even see them that they're going to be long*
303 *term?*

304

305 Oh yes, I mean quite a few of these I've picked up in inpatient emergency admissions,
306 very severe, chronic cases.

307

308 *Does line management play a role in keeping you focused or monitored, or...?*

309

310 No.

311

312 *Supervision?*

313

314 No, not currently. I used to see X. irregularly.

315

316 *X?*

317

318 X. And I used to come and discuss cases with S. for quite a while. But what does happen
319 informally and in D. is that all these cases that we're discussing, longer-term ones, with
320 obviously maybe the occasional exception, but the vast majority, we're discussing them
321 all the time.

322

323 *Does that affect you in terms of focusing more, or, hanging on, or discharging?*

324

325 Well, various... No, sometimes it facilitates a decision. But, you know, and the CPAs,
326 there's quite a few of them as well, so I mean, you know, there are lots of inputs about
327 where we are and what we should try to do.

328

329 [pause]

330

331 *So you, you said there's only a small proportion of your caseload that's unmonitored.*

332 *What's the unmmmonitored proportion?*

333

334 Well I mean if people who are may be a direct referral from a GP, that patient comes and
335 sees me, I work with them and that patient goes away, so no other component of the
336 service either knows them, has met them, or is involved with them.

337

338 *So, they're more likely to be the more straightforward ones?*

339

340 Yes. Yes. Yes, I was contrasting that with these more complex ones, long-term. Usually
341 there is some other involvement as well.

342

343 *So, it sounds as though in your case these longer term people are all more complex*
344 *severe personality disorder people, and they're known about to the rest of the team,*
345 *they're discussed openly?*

346

347 Yes, the majority.

348

349 *Because...*

350

351 They're not all necessarily personality disorders, it could be severe PTSD occasionally.

352

353 *Yes.*

354

355 And obsessional disorder.

356

357 [pause]

358

359 *Because some people have seen it more as having a shameful secret.*

360

361 Sorry?

362

363 *They've seen...*

364

365 (laughing) What, having people over twenty-six sessions?

366

367 *Yes.*

368

369 Yes. (laughs)

370

371 *But it sounds as though you don't.*

372

373 I remember someone who had better remain nameless, who, in the early days, well, in this
374 department, shall we say, was supervised by an eminent academic psychologist, and this
375 person's only training in what was then behaviour therapy, and the contract was
376 terminated, I think like fourteen sessions, but in actual fact the therapist continued to see
377 the patient for another year or two. (laughs) It wasn't me. No, not at all, no. I mean I'm
378 not saying I do the right thing, I'm not saying I do the best thing at all, but, it feels more
379 right for the system, and the circumstances that you work within. And it's not ideal but
380 you have a duty to the patients not occasionally have to [inaudible] be alive the next day.

381

382 *So, you... Mm. You actually sound as though you are in less conflict about it all than*
383 *some of the other people I've interviewed, that you feel....*

384

385 I don't live a life of conflict. (laughs) I think I want to resolve conflict, instead of
386 something you can't resolve, I've mentioned the frustration of the health care system
387 earlier.

388

389 *So what do you do about that?*

390

391 Oh, brief despair.

392

393 *Brief?*

394

395 Oh yes. Lots of other things to do. It's not my responsibility.

396

397 *Right, we seem to be whizzing through that.*

398

399 Good.

400

401 *So, well... (laughs) What about the sort of rescue factor, feeling that, maybe getting the*
402 *feeling from the patient about wanting to rescue them?*

403

404 I mean, some people need a bit of rescuing limited reparenting, yes. That's not a thing I
405 carry in my shoulders alone. Certainly if they're still inpatients obviously, you can
406 establish sometimes productive and supportive relationships with nursing staff, you
407 know. The chap I mentioned who I want to get to take the dog out for a walk, has formed
408 very strong attachments to two nurses, one male, one female, so it's not sexual or
409 anything. And that was very important, because, you know, it also allowed me to begin
410 to, continue work with him, there are people there who could listen. As time passed he
411 kept discovering all these people who weren't bad. (laughs)

412

413 *Do you...do you ever get attached to a patient?*

414

415 Attached? No. I'm fond of some, and admire. My experience of those with severe
416 problems is that I am just amazed at the resilience and the guts, the effort they have to
417 make to keep going compared to us, that, they certainly deserve help and support in a
418 world of many less desirable causes. But attached, no, I don't think so. I mean I've
419 described some patients who, I'm fond of them, I like them. I wouldn't like to say what
420 percentage. But there's none I dislike; some irritate. There's one actually I'm a bit wary
421 of, I've seen for years, there's a mixture of personality disorder, drug addiction and
422 probably a bit psychotic, and been in prison several times. Just slightly wary, he's a bit
423 unpredictable in his behaviour. I wouldn't say that I'm enormously delighted to see him .
424 [telephone ringing]

425
426 *I won't answer that.*

427
428 All right.

429
430 *Well, I suppose....*

431
432 [break in recording]

433
434 *Trust issues? Does it take longer sometimes because a patient takes a long time to trust?*

435
436 Or not trust at all. Yes.

437
438 *Yes.*

439
440 I mean it's a very vexed question. At the moment, well I have a male Dutch chap who...

441
442 *Male...?*

443
444 Dutch chap, R..

445

446 *Yes, as a psychologist, not as patient.*

447

448 *As a male trainee, a male trainee.*

449

450 *Yes.*

451

452 *And some woman who can't sit in the room with a man. There's no chance of trust there*
453 *I'm afraid, we try and shuttle them off. (laughs) And that trust I think is variable with*
454 *women who have been abused, and some men as well who have had a tragic upbringing,*
455 *don't trust anyone. And they may be uncomfortable too with a female and so on. So trust*
456 *is a big issue. As with everything, if you engage properly you work properly, then trust*
457 *exists.*

458

459 *But, so... Yes. So engagement, is that one reason why it takes longer because it takes*
460 *longer to get engaged?*

461

462 *I don't think it would take more than twenty-six sessions to get engaged. (laughs) I think*
463 *I'd have given up by then. But I think it...I think certainly, I think it can... I think*
464 *sometimes it doesn't happen.*

465

466 *The trust doesn't happen?*

467

468 *Mm. People remain very wary. I think certainly, certainly several sessions often used to*
469 *get people to begin to feel that we were trying to work with them, to help them. Perhaps*
470 *longer in some cases.*

471

472 *[pause]*

473

474 *Right, so, is there anything else you want to tell me?*

475
476 Not really, no. [pause] You know, I mean I think the way I work is obviously something
477 to do with me, I mean it goes without saying. But that me has changed over the decades,
478 you know, so... I think that'll always happen and that should happen. But a lot of the
479 way I work I think is to try to fit in and provide the best sort of service with the particular
480 skills and resources psychology has in Fourth Team, to the service and the community as
481 a whole, rather than just do defined operations.

482
483 *Rather than...?*
484
485 Do just the defined operation. So it's a bit broader, sometimes a bit vaguer, and
486 sometimes a bit more diffuse than it should be or that you might find elsewhere. That's
487 all. I'll go and play golf now. (laughs)

488
489 *Well, how's it been, being interviewed?*

490
491 Well, I mean obviously it's...it's very helpful to be forced to reflect upon what you're
492 doing. I think it's very... I think one feels that one is protecting one's position rather than
493 looking for faults in it, and justifying it. But other than that...

494
495 *Anything you'd see differently now?*

496
497 I might count the number of sessions.

498
499 *Yes, that's not on the tape, is it, that you don't count...*

500
501 Well, I think I've got a rough... I know.

502
503 *Yes, I know, I know one always has to...*

504

505 Yes, of course I know. I know when I'm seeing someone for the twelfth time or the sixth
506 time.

507

508 *I always do, it's part of what I do.*

509

510 Yes. But what's happened in the last year or two is that the psychology routine data
511 monitoring, you know, has broken down in Fourth Team (laughs), and I haven't been
512 writing down an actual number for patients for a long time. And I'm trying terribly hard
513 to be a good boy and get it started again.

514

515 *Right, shall we stop there? Thank you very much.*

516

517 If that suits you, yes, it's for you... Yes.

518

519 End of Interview

520

.....ask you about why you've offered patients twenty-six or more sessions, and it may help to think about specific patients, but it's your decisions that I'm interested in.

OK.

So when do you decide to...?

Well, it's often not a decision. The kinds of people who I take on are, and who are referred to me, are nearly always people with very complex longstanding problems, who have had lots of previous treatment. The intention is, in some cases, to start with a trial run to see if they will respond to cognitive therapy, and in practice, most of them show some signs of responding, and so one continues with them. That's not a very good answer is it?

Is that something that was agreed with a line manager?

Yes, yes it was. So, in a way it's been providing a special service, though I have also borne in mind that it should be as brief (laughs) as possible. And I've not looked at my caseload ever to...from the opposite angle, which I think I should do, which is to see how many I see in under twenty-six sessions, because in a way that would be quite unusual.

To see people for less than twenty-six?

Heavens. I'm sorry, it may be fifty-fifty, so it may not...but you know, it's...

Has it always been like that?

No.

30 *So can we maybe look at that separately, in the days when you maybe were more under*
 31 *the ten-session pressure, and now when it's sort of been...*

32

33 Mhm. Where the ten-session pressure is no longer there.

34

35 *Well, I...*

36

37 Or not in the same way.

38

39 *Not...not...or not for you in the same way, which sort of patients you're seeing at the*
 40 *moment.*

41

42 Mm. I'm not sure that I'll be able to make much of a distinction, but I'll try.

43

44 *Well, if you can't, you can't.*

45

46 OK.

47

48 *So in the past, at what point or points did you decide to make it a longer therapy?*

49

50 [pause] I'm muddled by the question. Do you mean, when we were operating the ten-
 51 session limit?

52

53 *We still are operating it.*

54

55 [pause] Well I would say...

56

57 *Or when you....*

58

59 ...we're not, or I'm not.

60

61 *You're not, no. When you were.*

62

63 Then, that decision would have been made in the last few sessions before we got to ten.

64 But that would have been made to prolong it, and then that would have been repeated,

65 because, I also reviewed every ten, and I think we all did at that stage. Though I must

66 have had an internal memo to myself with some people that we'd be unlikely to finish

67 before, or within a limit.

68

69 *So what sort of people would they be?*

70

71 Predominantly they'd have been people with child sexual abuse histories; with very

72 disrupted relationship patterns; with self-harming behaviours; and probably very poor

73 social support. So, with very little in their lives, maybe in terms of work or friends or

74 partnerships, or children. So they'll often be people for whom therapy became very

75 important if it got going.

76

77 *If it got going?*

78

79 If it got going. And of course it didn't sometimes, so I must remember that, because of

80 course the people that dominate my memory are the people who I'm seeing for the

81 longest times.

82

83 *So what's the difference between the people who don't get going and those who do?*

84

85 [pause] I don't know. Between them, or...? Once again... [pause] I'm just...I'm just

86 trying to think of cases. The people I go on with are likely to be the people who engage

87 well in the end, and with whom I have the sense that there really is some potential for

88 change, or genuine movement, or fluctuating movement, so that they make gains and then

89 lose them. For instance, I had somebody who used to say to me, 'I'm standing but I'm

not yet walking.' And, I knew exactly what she meant, and I think she had fifty-eight sessions. But by the time we got to the end she knew she was walking, and we'd phased out over a long period. So that's the kind of person I'd go on with. But I also have recently by mistake gone on with people who were failing, and...or, I have one dramatic case like that at the moment, who I probably should not have gone on with.

So why did you go on? And why shouldn't you?

Because I had learnt...

Why should you have stopped?

OK. I thought that I had learnt how to do this sort of work, and that eventually I could help these people change, even if it took a long time. And I think I was wrong in this case. And that going on, because it wasn't working, has actually made things worse. And so I've been thinking about how I could have known that earlier, and whether I've actually lost the thing you were trying to get at earlier, the assumption that I'm making a decision about who to go on with and who not with. I think... And who not. I think I had been working with the assumption that I can get somewhere with everybody, which is a bit arrogant.

So at what point did you say to yourself, I'm not getting anywhere, and I'm not going to get anywhere, but you're still carrying on with this person?

No, I've stopped.

You've stopped?

Well I'm doing a sort of holding business until another system is set up, that, then there's going to be a stop.

120

121 *You're going to pass them to somebody else, another system?*

122

123 Mm, a system rather than a person, because I think our service is so unable to provide
124 what these people need. That is another of the reasons why I go on with people, the
125 provision is so poor for these people...and the multiplicity of people involved with them
126 is so great that there's a lot of, a lack of consistency in their management. So they may
127 well be involved with their GP, with a psychiatrist, with social workers; maybe with the
128 day services, or with alcohol services or something, and these services...or with, a
129 specialised service is another one that they get involved with, or with a self-harm service.
130 And, there's a tremendous lack of coordination and consistency, and I have felt often that
131 it's been economical for them to be involved with one person, provided that takes the
132 strain off the rest, and they're seeing less of the rest. And so if the engagement is going
133 well, and that works, then, I stick with it. And you're quite right, with that one person,
134 my involvement had no effect on lowering demand on other services, or on lowering
135 frequency of crises. In fact, social services, police, the law, the GP, the psychiatrist, you
136 know, everybody's been constantly involved with these people, and constantly dropping
137 them, constantly saying, 'There's nothing more we can offer, she's not willing to help
138 herself.' And so, I've persisted thinking that's a very unfair judgement, and the service is
139 letting this person down. I actually still think it is letting this person down, but I don't
140 think the service I'm providing can fill the gap. So I certainly have taken on a bit of a
141 personal inappropriate crusade perhaps. I mean it's not quite that is it, but... But
142 there's...certainly I feel there's a commitment that I can make, and have been allowed to
143 make by my manager, that it's efficient and economical to make. And I've also found it I
144 have to say very interesting. So it suits me, and I felt it suited the service.

145

146 *So are there many where you make this kind of mistake?*

147

148 Well there haven't been until recently.

149

150 *Right.*

151
152 If I'm in doubt I always bring them to the CBT supervision group or to other supervision.
153 And I recently brought another one to the CBT supervision group, and received the strong
154 advice from everybody, 'Don't stop,' because the question I brought was, how do I stop?
155 Because I think that, I've got as far as I can with this person, and I think in this case it's
156 about twenty-eight sessions, so they're probably only just over the twenty-six. And their
157 strong advice was, there's a big risk of losing the gains you seem to have made, if you
158 disrupt this at the moment, and it really wouldn't be efficient, and other services have
159 dropped off, so there aren't...there is no longer the additional support system around this
160 person, but they are much better. And instead of saying, now dropping them, you really
161 ought to ease out, but keep a contact for quite a long time in the future. And I must
162 admit, that was music to my ears, because it was rather what I felt like doing, but was
163 feeling guilty about going on.

164
165 *In the past did you feel guilty about going on?*

166
167 Oh yes, I've often felt guilty about going on. And particularly when you know how big
168 the demand for these, how poor the service provision is I should say, for this patient
169 group. And I think I've argued to myself that, better to do one thing properly than two
170 things improperly.

171
172 [pause]

173
174 *Do eat if you want to.*

175
176 I shall make an awful lot of noise. Thank you. [packet rustling]

177
178 *So what do you call long term, how many sessions would you say that is to you?*

179

180 Oh, I would say, you know, anything over twenty. I mean I suppose twenty is quite long
181 too.

182
183 *Have you realised before you've taken somebody on, particularly perhaps more in the*
184 *past than now, that they were going to be a long-term proposition?*

185
186 Mhm. Particularly when for instance there are legal issues, and self-harming behaviours.

187
188 *What sort of legal issues?*

189
190 Taking previous abusers to court.

191
192 *Oh right.*

193
194 I've had a number of cases where people have been trying to sue the social services in
195 whose care they were abused, and the cases drag out forever, and are very very painful.
196 I've had another with a road traffic accident, one dragging on forever. Somebody who's
197 had multiple traumas of various kinds, including a road traffic accident. I'm getting
198 embarrassed by the noise of this. (laughs)

199
200 *As long as you're clear, it doesn't matter. So in those cases where it drags on, are you*
201 *doing therapy or support?*

202
203 Oh, I always think I'm doing therapy, and I could be wrong. I try very hard to do therapy
204 not support. So, and I do that by trying to structure it using the cognitive model and being
205 clear about a formulation. And trying to be explicit about what I'm working on with
206 somebody. Do examples help?

207
208 *Yes.*

209

210 So there's somebody who was chronically depressed, and it was eventually agreed that I
211 could see this person for six sessions a year.

212
213 *Agreed with...?*

214
215 With management – oh with the Trust in this particular case, and with the GP. So, so
216 instead of...so altogether this person had, I think in the region of eighty sessions, and...but
217 they were spread over ten years. And at a period we were having just six sessions a year.
218 And in the end this person would come in and say, 'I'm going to work on my
219 responsibility schema this time.' So she had the language. That's the point I'm making,
220 that, that it wasn't support, it was in that particular case, I would call it schema-focused
221 therapy I suppose, but, it was definitely informed by a shared formulation, an explicit
222 understanding of that, specific foci, if that's a word, for things that we've been working
223 on. A totally different type of example, if that's useful, is somebody who had had a most
224 horrendous childhood, came out of that, went to university, and then was horrifically
225 raped by somebody she knew. Came to treatment twenty-five years later. Had never got
226 over the rape, which had basically endorsed her sense of being valueless, and that nobody
227 would help her and all that. And, she just eventually took off in treatment in her own
228 way. So although it wasn't...it was definitely not support, and it wasn't structured
229 cognitive therapy, she would never have said, 'I'm going to work on my responsibility
230 schema,' she did a lot of choosing the particular focus for her, and writing about it, and
231 then, together we would try and bring the learning that she'd got from that into the
232 present, so that she could change her behaviour in the present, and endorse the new, the
233 new strategy, new ways of being, new perspectives on the world. So it felt to me very
234 constructive. I mean that's just one of the ways, one of the reasons I love this sort of
235 work, because it seems to me that the people are so very different and they do it in very
236 different ways. Somebody who, who worked mainly through drawing, and was able to
237 gain a lot from that, but couldn't talk to me, but she could talk to her pictures, at first.
238 Mm.

240 *Do you think you sometimes go on seeing people for longer than you might need to?*

241

242 Than I should. [pause] I... Well, I think the feeling I have about that now is that I never
 243 used to but now I do by mistake. And I think I never used to because I was clearer about
 244 what I was doing, it was newer work, and I was putting more new thought into it. I could
 245 also be wrong of course. Now I think I know how to do it, and I think that's led me into a
 246 whole lot of difficulties. I think I'm...you know, because I think... I think I haven't been
 247 clear enough about what I'm doing, and I've allowed myself to drift, and be what
 248 I...excused myself, and I've drifted by saying it's creative and interesting. (laughs) But I
 249 think sometimes it hasn't been. And I was very shocked when somebody just didn't
 250 come back, who I thought I was getting on well, very well, and wouldn't communicate
 251 with me about why they didn't come back, and that was the first time it had actually
 252 happened to me in ten years, or more. And I never knew why. But I did have an
 253 uncomfortable feeling that I had been listening without adding sufficient structure or
 254 additional guidelines for her about what to be able to do. She, she had under twenty-six
 255 sessions, but, so I don't know if you... Well she voted with her feet. But I think, I think I
 256 may have drifted away from the structured part of therapy too much.

257

258 *Mm. Do you still do the ten sessions and review?*

259

260 I start off saying I'm going to do that, and I do review. And I don't know whether it's
 261 because of the kinds of cases that other people refer to me now. I don't think I... I very
 262 very rarely stop in under ten sessions. I have recently stopped one person who decided
 263 that she didn't want therapy at all, in about ten sessions, and another who's done an
 264 amazingly rapid piece of work in about twenty. So I think I'm quite aware if somebody
 265 doesn't want to go on, and if they're improving fast enough to accelerate it, and stop.
 266 I've lost track of your question there.

267

268 *Whether you're still doing ten sessions and reviewing.*

269

270 Mm.

271

272 *Or reviewing every ten sessions.*

273

274 No I'm not reviewing every ten. I am reviewing regularly. And I do have a plan, so I
275 write down on my session sheet something, plan, in big letters, ten more sessions working
276 on X, and then I put, two out of ten, three out of ten, for the next ones, so that I keep, so
277 that I know when to review. The other thing I do is prompt myself to review when, if
278 there are natural breaks, like somebody goes away, or I have a break. And I try to use
279 those reviews as opportunities to re-plan, to... I wonder if I'm making it sound more
280 structured and focused than it actually is.

281

282 *So when, how do you decide to stop?*

283

284 I think above twenty, or, perhaps it's a bit more than that. I'm always thinking, how are
285 we doing, isn't it time we put a limit on this. I have to say, except with one person, I've
286 got one dramatically difficult case at the moment who's had fifty-one sessions.... When
287 we do do reviews, she always hooks me in to going on, by saying something to the effect
288 that she is making changes, it's the first time she's been able to, it's really really
289 important to her. And she's frightened she'll lose them if she's stops. (laughs) And I'm
290 seduced by it all, it's true. [pause] There's another factor though, which I might as
291 well...which is certainly a personal feeling I have, about the horror in these people's lives,
292 and the disadvantage they've suffered, combined with the poor service provision, I mean I
293 feel they deserve it, you know, personally. And I suppose that's a duty to me too. Having
294 got here, having been able to talk, and assuming that, you know, if they've got on that
295 long, they've been able to make a relationship, and to gain something from it, then it's
296 important, and it seems to be important to go on, so... But the question you asked was,
297 how do I stop?

298

299 *How you decide to stop.*

300

301 I'm always thinking about it once people... So what tells me? [pause] A sense that the
302 changes are... All sorts of things. A sense that the changes have gone as far as they can;
303 a sense that they're solid and therefore not going to dissipate as soon as you stop;
304 sometimes a sense that you might want to do some more work but say in eighteen months
305 or whenever, so then, what would help now is a consolidation period. So I'm very aware
306 of the possibility of encouraging too much dependency and working always towards
307 fostering somebody's independence and ability to make choices and decisions that are
308 functional for them. And as people do that, it would certainly come to my mind, now is
309 the time to stop, and to endorse that, and to endorse it by not being there for them, so they
310 can do it on their own.

311

312 *So, you've been saying something about, that you get something out of this work.*

313

314 Mm, mm, mm.

315

316 *You find it very interesting.*

317

318 Mm.

319

320 *You've also mentioned how it can be something about the patient, that they hook you in...*

321

322 Mm.

323

324 *...sometimes...*

325

326 Mm.

327

328 ...into continuing. Would it be other things about the patient as well? Like making you
329 feel guilty, or maybe even not liking them that much and feeling guilty? Or liking them a
330 lot?

331

332 I'm not aware of those things influencing that decision.

333

334 Or if they come up with crises all the time, so you sort of can't stop?

335

336 I mean I've mentioned feeling that the service provision is so bad, so I suppose that
337 would be a bit...there's a guilt thing, is that what you mean?

338

339 I was thinking of a more direct guilt, rather than an impersonal guilt.

340

341 That I would be doing something wrong if I stopped? [pause] I don't think, guilt doesn't
342 really come into it for me, I don't think, unless I'm misunderstanding the...

343

344 Do you ever feel guilty for carrying on?

345

346 Oh yes, I do. I mean I do feel ashamed rather than guilty. I mean I feel, I can't be doing
347 this well enough, I should be better at this. There are other people waiting. But then I
348 also so to speak excuse it by the thing I said before, about feeling, better to do one job
349 properly than two jobs badly. [pause] I was going to say something else, it's gone away,
350 I'm sorry.

351

352 Excuses.

353

354 Excuses.

355

356 For carrying on.

357

358 I've been terribly sad to lose some of these people, but I'm absolutely certain in my own
359 professional mind that I've not carried on longer than I should have done, and one reason
360 that, one way I make that easy so to speak for me is, thinking about ending from, as soon
361 as I can, but also – and talking about it openly – but also having a tailing-off period so
362 that you have periods when you might meet every couple of months, or, you know, as you
363 ease out with the follow-up.

364

365 *What about a need to rescue somebody, wanting to rescue?*

366

367 I don't think that's part of it for me, because, if that was it, you know, I'd be running a
368 hostel or something. There are so many people who need to be rescued. I feel quite...you
369 know, I feel a sense of humility, a sense of, you know, really privileged to be able to help,
370 and to be told the things I'm told.

371

372 *What things?*

373

374 About the awful things that have happened to people largely. And how they feel about
375 themselves as a product of that. And the intimate details of their lives. I don't think I feel
376 the need to rescue... I feel very very pleased when people begin to change, of course. So
377 that's the reward for me, and sharing that with them, and of course they're pleased too,
378 so, you get the reward from them. And I think I feel...and I think that's what's made me
379 go on too long with the one I was talking about before, in a sense of that, I knew we can
380 get there, I know we can get there, and we didn't, and I think I made things worse, so, I
381 do need to rethink that.

382

383 *So what about the relationship between you, is that a factor?*

384

385 I need a more precise question. I mean of course the relationship one makes is one of the
386 most important things about it, but, the factor in what?

387

388 *Carrying on, giving longer therapy.*

389
390 No, I don't think so. I mean... Sorry about this. Crumbs all over your room. It's a factor
391 in the pleasure I get out of it. [pause] The person who voted with their feet and didn't
392 come, I really really liked, and I thought we had a good relationship, and I did ask myself
393 in that case, you know, it was not a long treatment, whether my liking for her had been
394 one of the things that had put her off somehow, and then prevented me being more
395 objective and structured. But as I like lots of them, and all of them, I'm not really sure
396 about that.

397
398 *Do you ever dislike anyone?*

399
400 Temporarily. I mean they can exasperate me, all of them.

401
402 *Even the one that...*

403
404 I mean you can go through...

405
406 *...you inherited from me the one that walked out?*

407
408 I can't remember which she was at the moment.

409
410 *I don't want to say her name.*

411
412 Oh. She exasperated me, but I was always interested and curious, and fascinated, and
413 trying to understand, and indeed she didn't get very far. But then because she was a
414 research person, there was a reason for stopping. But I do ask myself questions about
415 whether I'm doing these people a service in the way that I think I am, because I may not
416 be, it could be an illusion. And it could be that they benefit more from something else.
417 But as that something else isn't available, they've got me, and that seems fine. (laughs) I

come free; most of the other things they have to pay for. That's another big factor for me, doing it for the NHS, a really big factor. I think these people, though I say it myself, are getting a high quality service that they deserve.

What about things like motivation, patients' motivation, or getting engaged in therapy?

Mm. I find, I treat those things in my mind as being puzzles to solve, I suppose. So often it's difficult. I think the cognitive model is so helpful, I really really do though. So if somebody doesn't engage, doesn't do things, doesn't appear motivated, it's because of their perspective on the world. That's one of the stories you can tell yourself. So then you can get interested in their perspective on the world, and on how you can shift that, which is the whole essence of cognitive therapy. So it does engage my curiosity. I also quite frankly think I'm good at it. (laughs) I mean I think I'm good at engaging people who don't want to engage. I mean I don't know how I am, or why I am. I think I can do that bit. I think the bit I'm not good at is facilitating people going deeply into really painful stuff, and a lot of the work that I do involves understanding the meaning of the painful stuff, rather than wallowing in it, and I sometimes ask myself whether I'm avoiding that personally for me, or whether I'm using the cognitive model in the way that it's helpful for it to be used. I think that's an unanswered question.

By looking at the meaning you're standing back from it.

Yes. And I'm... But you see of course, what one's trying to do in a way is to help them stand back from it, and I've got one person at the moment who can't, and isn't, and I'm finding that very difficult. [pause] And so in a way my frustration and exasperation with him is the same as it would be with any human being so to speak, any relationship, it's bound to be there to a degree, and so it's more of a question of how one handles it than being bothered by the fact that it's there. [pause] [bag rustling] I think for the sake of your transcriber, you need to know that the hospital sandwiches fall apart.

448 *Yes, they are disgusting, on the whole.*

449

450 *And are in crinkly paper. [blowing crumbs] I must try and rescue the situation.*

451

452 *And these patients, these longer term patients, now and maybe even more so in the past,*

453 *would you have talked to other people about them, or had them as what somebody else*

454 *has referred to as a shameful secret?*

455

456 *Oh, my... None of these were shameful secrets, so, I don't like being in that position, so*

457 *I'd always have talked about them, and somebody would always have known that they*

458 *were long-term cases; maybe only X. but somebody would have known. And I would*

459 *bring them to a supervision group, and I would seek supervision when, with difficult*

460 *issues concerning them, most with specific people in the department usually.*

461

462 *Supervision from people in the department?*

463

464 *Yes. So... I wonder if I'm mis-remembering that from the past though. It could be that I*

465 *did have a sense of doing something wrong, going on too long.*

466

467 *So what role do you think supervision does play, does it help you to focus, does it help*

468 *you to stop, carry on?*

469

470 *I've used supervision more frequently at the beginning of an intervention with somebody*

471 *than towards the end. It helps me then to formulate, to find a focus, to understand. In*

472 *some cases it's really felt like sharing a burden, and a sense that it wasn't clear what to*

473 *do, but it was worth having a go. I mean it's interesting that you ask that when I have*

474 *also already mentioned bringing somebody to supervision because I felt I should be*

475 *stopping. And I do sometimes do that as well.*

476

477 *In order to help you stop, you mean?*

478

479 To... Yes, or, in order to discuss the issue of whether to now. [pause] It's quite
480 interesting, when I look down the list of people. There's usually been a reason for
481 stopping, it's been quite... [pause] Mm, why did do people stop? [pause] In most cases
482 they just feel they've gained enough for the time being.

483

484 *And you say that line management has currently given you permission to carry on, and in*
485 *the past you let X. know about these people. Has she, has she...*

486

487 I mean there have been other people in the Trust who have known, and I don't know if
488 that's relevant for your research, but, there was a stage way back when I talked to one of
489 the psychiatrists who was here, had been here for a long long long time, about the issue,
490 who actually said to me...

491

492 *Yes, I remember.*

493

494 Can you remember?

495

496 *Who came down here, a woman.*

497

498 Mm.

499

500 *Mm.*

501

502 But who actually... We had a long discussion about the kinds of people who were willing
503 to be involved with these sorts of complex and difficult and demanding cases, with a
504 sense that if people were willing to, then although it wasn't something the Trust
505 acknowledged they were providing; it was something valuable. And most people who
506 have been here a long time had one or two such cases on their books; if they were
507 prepared to, that was a valuable thing.

508
509 *Yes, well she has someone that we've both involved, been involved with too.*
510
511 Mm. Mm.
512
513 *Who I've heard from recently.*
514
515 How interesting.
516
517 *Mm. I'll tell you afterwards.*
518
519 Mm. Mm, I'd love to hear.
520
521 *So then actually factors in the Trust that...well, give you permission occasionally.*
522
523 Mm, occasionally.
524
525 *And rather...*
526
527 Not only there though.
528
529 *But rather informally though.*
530
531 Mhm. Except for the one case when I was allowed to see somebody for six sessions a
532 year. I mean that was a proposal I made, together with the patient, that went to my line
533 management here, to the psychiatrist involved and to the GP. And everybody saying they
534 thought that that would be a good use of services. Mm.
535
536 *So do you ever get pressure from other services or other professionals to carry on? I*
537 *know you've said you see it in the context of other services...*

538

539 Mm.

540

541 *...but do they say, 'Oh you can't stop seeing this person now'?*

542

543 Mm. Sometimes. Sometimes there's the opposite, rarely, but there is sometimes the
544 opposite when somebody starts talking about things, you can't stop them and they get
545 fantastically distressed, and provoke crises in their lives, and then people say it's all you
546 cognitive therapists making them worse, and you shouldn't do it. And one can come
547 across quite a lot of anger. So, I've been there too. (laughs) [pause] And then there's
548 the other thing that happens, which is that, which I think is really...I wish we could
549 change, which is that, people hold on to somebody who's in crisis, saying, 'Eventually the
550 psychologist will see you. And then, they'll deal with it, and it'll all be better.' And
551 one's, you know, set up to be the person who's going to change a situation which is
552 probably impossible to change.

553

554 [End of Tape Side A]

555

556 [Tape Side B]

557

558 Well I'm not fond of going back to the referrer and say, 'Don't say that ever again,
559 consider your wrist slapped.' (laughs) I do try and disabuse the patient of the view that
560 there's one answer and it's coming from me. But you...I don't want to dash their hopes
561 either. And then of course I suppose at some level I think there is one answer and it can
562 come from me. (laughs) I don't actually, but, you know, one might hope that.

563

564 *Well that, that sort of brings me to, that, sometimes one may have felt that, all these other*
565 *people haven't been able to help, but I am going to be the one.*

566

567 Mm.

568
569 *Or they haven't had a proper therapy yet, such as I'm going to provide.*
570
571 Mm. [pause] I'm never too sure about that line, because I never feel sure that I'm
572 actually providing therapy properly or right. Because, one has to be so creative in its use.
573 And so, I've fallen off the straight and narrow. So it isn't, you know... That...that bit I'm
574 embarrassed about, you know, I feel if anybody listened to my tapes they'd think, what on
575 earth does she think she's doing? [pause] So... I do... I don't think I have much of a
576 sense though that, what I can provide is the one and only thing. No, I don't. I have a
577 different view, I have a view which is that, there are many different kinds of therapies,
578 and some of them are far more sophisticated than cognitive therapy was until recently,
579 and probably still are, much more sophisticated in some respects, and they know things
580 that we don't. They do things that we can't. And so, there could be a better option for
581 this person than I can provide, but it's not available for free on the health service, or
582 locally, or readily.
583
584 [pause]
585
586 *Well I guess we're coming towards the end now. Are there...is there anything else?*
587
588 About...
589
590 *...you want to say?*
591
592 *...working long term?*
593
594 *Any of this.*
595
596 I can't think of anything in particular. I'd hate to stop doing it. I do think that one
597 develops and changes as a therapist – well, which I've always known obviously, and that

598 one can lose one's edge as well as gain one's edge, and I wonder at the moment, because
599 of having particularly difficult cases, and this one that I mentioned to you about feeling
600 that I've actually made worse, or continuing has made them worse, I do sometimes, I do
601 think I need to pay careful attention to what I'm doing, and I wish there were more
602 supervision. I like to bend people's ear all the time.

603

604 *Yes. Yes, I do it all the time.*

605

606 Mm.

607

608 *I just love talking about them.*

609

610 Mm. [pause] Mm. Actually, one other thing. That there's an element of CBT training
611 and psychology training that always stays with me, which is in simple terms, at some
612 level it all makes sense, and if that's so, then understanding how it makes sense can help
613 one understand how to change. And also, the implication of that is that one always can
614 change and that you don't have to be stuck. And I think that informs my relative
615 imperviousness to pessimism with these people. And I think I've also been lucky, you
616 know, I've had wonderful patients who have responded, and maybe I've been
617 unlucky...you know, been particularly lucky, and only recently got the harder ones.
618 (laughs)

619

620 *There may be something about you as well.*

621

622 That would be lovely.

623

624 *How has it felt doing this interview?*

625

626 Mm, interesting. Concerned at times that I'm not giving you what you want, but... And
627 I've been talking about things that are of interest to me.

628

629 *Anything that you would see differently now?*

630

631 No. [pause] Though I'll go away thinking about guilt, because that's the question I

632 couldn't answer. Something I'm blind to here. (laughs)

633

634 *It's very convenient to be blind to that one. Shall we stop there?*

635

636 End of Interview

637